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THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
JOURNAL DE L'ASSOCIATION CANADIENNE
DES HYGIENISTES DENTAIRE

dent

PROBE

VOL 27, NO 1

JAN/FEB 1993 JAN/FÉV

D. COTÉ, RDH



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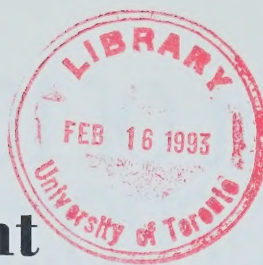
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References:

1. Hanna JJ, Johnson JD, Kuflinec MM. Clinical evaluation of sanguinaria-containing toothpaste and oral rinse. American Journal of Orthodontics and Dentofacial Orthopedics, 1989, Vol. 3: 199-207
2. Harper DS, Mueller LJ, Fine JB, Gordon J, Laster LL. Clinical efficacy of a dentifrice and oral rinse containing sanguinaria extract and zinc chloride during six months of use. J Periodontol, 1990; 61: 352-358





Distinctly Different

Across the country we've heard the ever increasing cry of "distinct society". Dental Hygiene echoes that cry; we too are a distinct society! We are, here and there throughout the land, achieving recognition in establishing our own governing bodies, becoming responsible in constructing our own quality assurance standards, and creating grant funds to assist our professions' members in furthering their educations. We're currently in the midst of developing our own focus of research. We've become effective lobbyists and educators. We're distinct from the dentists, our "father-figure" employers. We're all grown up!

The direction dental hygiene is taking is timely and admirable. I believe the movement is being conducted in a well-paced and logical sequence by capable and reasonable people. The framework for a true and fully emerged profession is being built, but are we following? We, the dental hygienists of Canada, are the fabric which will drape that framework. Are we apt to make it become a thing of beauty as we are stretched out over this noble pattern or are we of cloth so inflexible that we will collapse upon ourselves, destroying this carefully constructed base as we fall?

"Do you have a job or career?"

As we demand increased status we must be prepared to bear the responsibility it requires. We, as hygienists, are specialists to a degree, oral health promotion specialists. When I discuss a particular topic related to any specialists' field, I've found them, for the most part, able to enlighten me on the most recent developments. There is no question as to that specialist's right to be called just that, a specialist. I seldom detect any sign of reluctance to spend hard earned dollars on continuing education, coveted free time on journal reading or contributions back to the profession. True specialists display dedication and responsibility to their professions. Can we each say, "That sounds just like me"?

Do you have a job or career? I know some



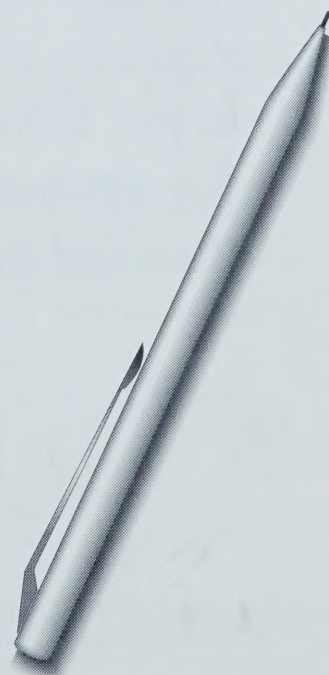
MARILYN GOULDING, RDH, BSC

hygienists who have jobs. I also know hygienists who have incorporated dedication into their jobs and have turned them into careers. Additional investment in further education and personal commitment to the profession has turned many of these career people into fine professionals. Now we must make this the rule rather than the exception. Our leaders have cleared the way for us to advance to a higher plateau of responsibility. We all want it; but are we willing to back them up and do what it takes to be worthy of it? It may be some time before all of our labouring hygienists transcend to having careers. It may even be longer before our career hygienists become true professionals. An "Act" does not a professional make!

Start planning your budget to include one major meeting a year; the American Academy of Dental Schools (AADS) if you're an educator, the International Association of Dental Research (IADR) if you're a researcher, the American Academy of Periodontology (AAP) if you're a clinician, and certainly the Canadian Dental Hygienists' Association (CDHA) annual professional conference, for hygienists of all

kinds. The only kinds you won't see there are hygienists with jobs!

Doors are beginning to open for us. We have to be ready to walk through confidently armed with knowledge and professional expertise. This is not something we graduate with; our diplomas merely give us the right to begin. This is something we continue to strive for and most likely never achieve. There is always new knowledge to acquire, new studies to read, new methodologies to assimilate, new treatments to apply, new experts to listen to and new skills necessary to sift it all and ultimately judge what we deem best for our clients and their health. We're specialists in oral health promotion; we're distinct. Are we ready? 



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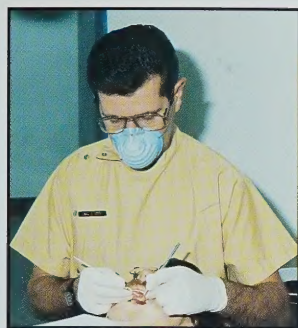
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COVER

*Introducing colleagues
from Coast to Coast:*
ADJC Denis Côté
*Canadian Forces Dental Services
Valcartier Base
Courcellette, Quebec*

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The Canadian Dental Hygienists' Association Journal: Probe is the official publication of CDHA. CDHA invites submissions of original research, discussion papers, and statements of opinions pertinent to the dental hygiene profession. All manuscripts are refereed anonymously. Contributions to Probe do not necessarily represent the views of the CDHA, nor can CDHA guarantee the authenticity of the reported research. Copyright 1986. All materials subject to this copyright may be photographed for the non-commercial purpose of scientific or educational achievement.

Infection Control

In his guest editorial in *Canadian Dental Hygiene/Probe* (Vol. 26, No. 3 Autumn 1992), John Hardie takes the position that "In dentistry, most currently recommended infection control techniques and products are ineffective, inappropriately used, and create a misleading sense of security." If his article is intended as a tongue-in-cheek attempt to stir up controversy, or more charitably, to stimulate thought and discussion, he has certainly succeeded. If, on the other hand, he really believes what he says, his untenable position demands a response.

The established routes of HIV transmission are sexual intercourse (anal and vaginal), injection drug use, blood and blood products (and in some cases transplanted organs and sperm donations) and vertical transmission from a mother to a baby during pregnancy or birth. The overwhelming evidence accumulated in the past decade indicates all of the above have been implicated in the transmission of HIV in Canada, as elsewhere.

Concerns about transmitting disease in dental practice are real. A recent editorial in *The Lancet* (Vol. 340: Nov. 21, 1992) lists sharps injury, unsterile dental equipment and cross contamination of the dental unit water system as potential means of the transmission of HIV during dental treatment.

Dr. Hardie is correct that the risk is relatively low as there is little evidence of either patients or health care providers having been infected through health care treatment. Nevertheless, surely the emphasis should be on providing the most secure environment for both patients and health practitioners. Is it too much to expect that providers use the best advice and technology available to stop the spread of any disease, let alone

one that is almost invariably fatal? Good public health practice demands no less.

Ron de Burger
Director
AIDS Education and Awareness
Program

Conference '92

I wish to congratulate you on the excellent summary of the June '92 Conference presented in the *Probe*. I always look forward to reading the *Probe*, for it successfully mixes interesting and informative papers with new product information, educational and employment opportunities etc. in a very professional and easy-to-read format.

Marjorie Burgess and I were both surprised and thrilled to see our picture in the national journal. We feel famous! Also, we do appreciate the acknowledgement within the article. Incidentally, it was a close friend and former classmate of ours, Lori Kerr, whose name was substituted for Marjorie's. Unfortunately, Lori

did not attend the conference with us. I really had an exceptional time in Victoria. As you can see in the photo, it was a time for a small reunion with another classmate, Jennifer Locke, Comox, B.C., and our instructor and mentor Lynn James, Fanshawe College, London, Ontario.

Upon my return to Toronto, I have spoken with a number of hygienists about the conference and what a positive experience it was for me. Others have now seen my picture in the *Probe* which gives me another opportunity to urge them to attend in '93.

Although Marjorie and myself are new graduates ('91) and have not had any previous experience at a national conference, we were very proud to be associated with the calibre of hygienists we met. We were impressed with the presentations, and made to feel welcome right from the reception/registration.

We look forward to the '93 Conference.

Eileen M. O'Neill, RDH



CDHA Conference '92 — Enjoying a visit to the Native Heritage Centre, from left to right: Jennifer Locke, Lynn James, Marjorie Burgess and Eileen O'Neill.

During the Canadian Dental Hygienist Association's Annual Board meeting in June 1992, the Management of Dental Hygiene Care Position Statement was passed unanimously by the Directors from each province. (The position statement was published in the Autumn 1992 issue of Probe.)

Provincially, nationally, and internationally dental hygiene is recognizing its role in primary health care and prevention. Health For All By The Year 2000 is the target of a social movement that began with the World Health Organization International Conference on Primary Health Care, held in 1978 at Alma Ata, USSR. "Health for all" does not mean the eradication of all disease and infirmity from the face of the earth. It, instead confirms the belief that health, social development and the economic environment of a country should be co-ordinated so that all people will have access to health care and the opportunity for a reasonable quality of life. It is



LORRAINE BOOMHOUR, RDH

with promoting health. CDHA's position statement states clearly that dental hygienists are primary health care providers. In the report of the Working Group on the Practice of Dental Hygiene by Health and Welfare Canada, 1987, it was noted that dental hygienists could provide screening, assessment, and preventive services in the setting of a primary health care centre.

Primary Health Care as stated in the Alma Ata Declaration of 1978 is, "The first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process."

The primary health care model includes a philosophy that promotes the appropriate and increased delivery of care at the access point of the health care system at a cost the community can bear. It refers to basic or general health care provided at the person's first contact with the health care system. The primary health care provider assumes responsibility

with the client for health maintenance (Faber Medical Dictionary Edition 16).

Health care by the people is the hallmark of *primary health care*: people determine not only their needs but also the programs and services that will meet those needs. The five principles of *primary health care* are: accessibility, public participation, promotion of health and prevention of illness, intersectorial co-operation, and appropriate technologies.

Dental hygienists across Canada have been working diligently to make changes in the legislation that regulates dental hygiene so that we can provide preventive care or primary oral health care in long-term care facilities, wellness centres and acute care hospitals. Dental hygienists are listeners, educators and counsellors. Hygienists have been educated to assess the patient, help the patient to understand and solve the problem and work with the patient to prevent recurrence. It is time for the governments to realize that prevention and wellness are the keys to direct government spending on health care.

My personal thanks to the members of the Practice and Regulation Council of the Canadian Dental Hygienists Association for their vision in preparing this statement for the board and our profession. I believe it will stand the test of time and serve our profession well in the future. 

Lorraine Boomhour, of Brampton, Ontario, received her Dental Hygiene Diploma in 1978, and obtained her Expanded duties in Dental Hygiene in 1979. She has been active in both CDHA and ODHA for many years, serving as director and president (1987-88) respectively. She is currently in private practice.

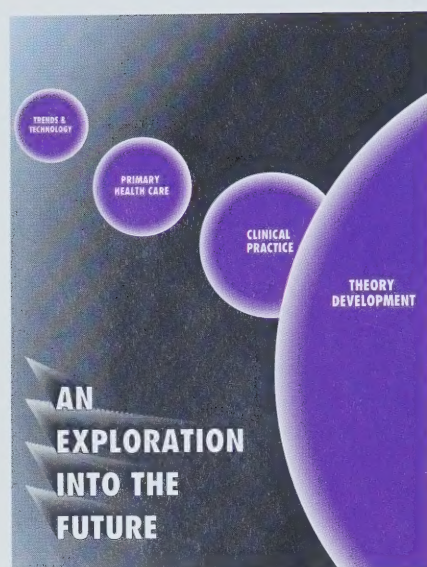
"Primary care is often mistaken for...the term primary health care."

proposed that the achievement of this goal should be through a new approach of primary health care.

Primary care is often mistaken for, or used interchangeably with, the term *primary health care*. However they are not synonymous concepts. *Primary Care* is a concept referring to a situation where the dentist or physician provides diagnosis, treatment, and follow up for a specific disease or problem. In *primary care* dental hygienists or nurses provide direct patient care and follow-up in relation to the treatment prescribed by a dentist or physician.

Primary care is an illness-oriented concept whereas *primary health care* is concerned

CDHA Professional Conference 1993



Program outline

Friday, October 15

Workshop: To familiarize interested educators with CORE (clinical outcome review and evaluation program).

Saturday, October 16

Keynote Address: Dr. Jane Fulton will elaborate on the need for research in dental hygiene, and the relationship of research to professionalism. The necessity of integrating theory and practice in dental hygiene will also be discussed.

Presentations: That will appeal to both practitioners and researchers

• **Remaining Current in Practice:** Role of the dental hygiene practitioner, whatever the work setting, in applying research ideas and/or methods to stay current. What activities can be undertaken by practitioners to assess and analyze their client care procedures, and how? For example, specific clinic record keeping can enable a practitioner to collect and analyze client information in a standardized way. What are the practitioners' limitations in carrying out applied research?

• **Using Research in Dental Hygiene Practice:** How do we transfer knowledge from research to practise? What are the barriers?

• **Submitting Manuscripts to *Probe* and *Dental Hygiene*** (our American colleagues' journal): Joint presentation by CDHA and ADHA on how to prepare manuscripts for submission to their respective journals. A review of the ingredients of a scientific paper and evaluation mechanisms used by both associations in assessing manuscripts for publication. Learn how to transform your expertise into the written word.

• **Understanding the Scientific Literature:** Why must dental hygienists examine the scientific literature and what is the importance of the literature in developing the "art and science" of dental hygiene? This presentation will describe the types of scientific literature, and the use of abstracts by dental hygienists.

• **Theory Development Workshop:** A working session designed to consider theories related to the practice of dental hygiene, how to categorize data to formulate theory, the structure and development of models, how to set up research to test models, and how to validate theory.

• **Free Papers:** Written and presented by dental hygienists

• **Commercial Exhibits** (all day)

• **Table Clinics and Poster Sessions**

Sunday, October 17

• **Testing and Validating Theory Workshop:** Designed to build on Theory Development workshop by examining "Human Needs Theory" or other appropriate theory, and the relationship of theory to dental hygiene practice. How do you test and validate such theory? What is its clinical application?

• **Mini-Sessions:** Explanation and examination of current research efforts which will affect the practice of dental hygiene now and in the future. Topics will include the use of lasers, saliva research, the use of computers for assessment and diagnosis, the purposes of microbiological testing, and research on health policy, demographics and economics.

• **Survey Research Workshop:** Survey research methods are frequently used by dental hygiene researchers to assess knowledge, attitudes, skills, beliefs, and practices. This workshop is designed to describe the purpose of survey research as well as offer participants a practical understanding of how to develop and conduct surveys. Means of analyzing survey results will also be discussed.

• **Qualitative Research:** Qualitative research design and methods are best suited for study questions about which little is known. The purpose of qualitative research is to describe a particular case or group of cases "in-depth" so that an understanding of detail and experiences can be obtained. This presentation is designed to inform dental hygiene researchers about the usage and strategies of qualitative research.

• **Common Flaws in Research:** A "learn from your mistakes" presentation on common flaws in research relating to methods, writing techniques, literature reviews, problem formulation, sample errors, external validity, statistical analysis, and survey design.

• **Corporate Panel — Discussion, Question and Answer:** Representatives of the "corporate world", government agencies and the dental hygiene community will discuss the influence of funding sources on current and future research, funding priorities, grantsmanship, and the role of the dental hygienist in oral health research.

Abstract Evaluation Procedures

Abstracts for papers, posters and table clinics will be accepted in two categories: (1) research and (2) new programs.

Abstracts representing **research results** will be evaluated according to the following criteria:

1. Are the purposes of the study identified?
2. Is the research methodology described?
3. Are the results reported clearly and concisely?
4. Are the conclusions supported by the findings?

Abstracts representing **new program information** will be assessed based on the following criteria:

1. Are the purposes of the program clearly stated?
2. Is the program's approach or design and/or key features clearly described?
3. Is the program innovative?
4. Has the program been adequately evaluated or will it be?

Authors should submit one copy of the cover sheet and four copies of the abstract (Appendix A). The cover sheet must include:

- a) Title of the paper, poster, or table clinic.
- b) Name(s) of author(s), indicating who will present; addresses and phone numbers.
- c) Employment title or position of author(s).

Appendix A for Abstract North American Dental Hygiene Conference Niagara Falls, Ontario October 15-17, 1993

Deadline date for Abstracts has been
extended to Jan. 31, 1993

First Author: _____

Affiliation _____

Address _____

City _____ Prov./State _____

Postal/Zip Code _____

Telephone: Bus. () _____

Res. () _____

Additional Authors (Names only)

It is expected that first authors will present the papers unless otherwise specified.

Choice of Presentation Format

_____ Oral presentation (Free Paper)

_____ Poster presentation

_____ Table clinic

Abstracts should be submitted to:

Ellen Brownstone, Dip. D.H., M.Ed.

**Co-chair, C.D.H.A. Professional
Conference**

c/o Canadian Dental Hygienists' Association

Ste. 201, 1018 Merivale Rd.

Ottawa, Ontario Canada

K1Z 6A5

Type perfect original of abstract here. Do not type beyond outline of box.
Include title, purpose, method & results.

Camosun College

Camosun College is pleased to announce the appointment of Marge Reveal, RDH, MS, MBA, as Co-ordinator of Dental Programs. Marge is a highly talented educator with a wealth of varied experience in dental hygiene, including having served as the president of the American Dental Hygienists Association.

The "newest" dental hygiene program in Canada, with its first students admitted in 1989, Camosun College has now graduated two classes. For the past three years, limitless time, effort and expertise has been devoted to developing and refining the academic and clinical program.

In the B.C. tradition, applicants must have successfully completed five first-year university subjects: English, psychology, biology, chemistry, and one elective. The professional program consists of two, ten-month years. The curriculum reflects the CDA National Competency Profile for Dental Hygiene and is designed around the principles of adult learning and AADS curriculum guidelines. It has several dominant themes and thirteen major objectives. The themes streaming through the curriculum include: problem solving, research, health disease continuum, responsibility and accountability. The major objectives are levelled, i.e. introduced simply in Semester 1, and further developed throughout the remaining semesters. The objectives include:

1. Apply principles of teaching and learning to provide dental health education to individuals and groups in the community and in practice.
2. Integrate professionalism into the practice of dental hygiene.
3. Apply patient care support procedures when providing dental hygiene care.
4. Apply the process of assessment (gathering diagnostic data), planning (goal setting); implementation (performing dental hygiene



MARGE REVEAL, RDH, MS, MBA

procedures); and evaluation (measuring the outcomes/results of dental hygiene care) when providing dental hygiene care.

5. Apply effective interpersonal communication skills with patients/clients, groups, colleagues, instructors and support staff.
6. Participate effectively within the dental team in the provision of dental hygiene care.
7. Demonstrate ability to respond to change by applying knowledge gained from research to dental hygiene practice.
8. Demonstrate a commitment to the concept of life-long learning.
9. Demonstrate responsibility and accountability for actions and decisions.
10. Integrate basic and dental sciences with clinical knowledge and skills when providing dental hygiene care.
11. Demonstrate a commitment to quality assurance through ongoing self, peer, instructor, and program evaluation.
12. Interpret research publications in related, professional literature.

Graduates of the program are able to assume the traditional dental hygiene scope of practice, but with special emphasis on management of dental hygiene care: patient assessment, treatment planning, pain control, and evaluation of care provided. There is special emphasis in the program on health promotion, care of non-traditional groups, and career development. Graduates

may access the Dental Hygiene Degree Completion Program at the University of British Columbia and/or University of Toronto.

The Program is housed in the Dental Health Education Centre in a new, modern, twenty-eight chair facility with a designated classroom, pre-clinical lab, four radiography rooms, and instructor offices. Library resources are available on campus and in the Provincial Library and through inter-library loans. The clinic serves the larger College community by providing dental health education, dental hygiene care and preventive services for self-selected and referred clients.

Along with twenty-four dental hygiene students in each year, forty dental assisting students study and practise in the facility. The two programs in association enjoy a particular synergy. Opportunities for cross teaching, team work and joint projects are encouraged and students gain an appreciation for their respective roles and abilities.

The faculty at Camosun College are experienced and well qualified to deliver the program. Their professional qualifications have been earned in Oregon, British Columbia, Saskatchewan, Manitoba, Alberta, Ontario and Nova Scotia, therein creating a broad perspective on dental hygiene practice. Faculty members hold degrees in education and business administration, biochemistry, biology, psychology, dentistry, and dental hygiene. Part-time, currently practising, highly skilled clinical instructors and lecturers, also enrich the program. With two years of graduates having successfully completed CDSBC licensing examinations and having joined the ranks of dental hygiene practitioners. The Program is looking forward to an external review by the CDA Commission on Accreditation in 1993.



National Dental Hygiene Campaign 1992

Dental hygienists across Canada and the United States were enthusiastically promoting oral care and their role in providing that care during the week of October 18-24.



CDHA's National Dental Hygiene Campaign, focusing on the Older Adult, was launched a few months earlier at the "New News for Older Smiles" Professional Conference in Victoria, B.C.



Some of the activities that dental hygienists were involved in during NDHC included: denture marking, oral cancer self-exams, nutrition counselling, older adult television programs, and magazine and newspaper articles. Look for more detailed news about the Campaign in the next issue of Probe.

The CDHA sweatshirts were a huge success — approximately 500 were sold — in fact, orders continue to arrive at central office, and they will be available for the remainder of the poster series. Campaign materials — fact sheets et cetera — are available year-round, so dental hygienists can continue their Campaign activities whatever the month!

Anti-cavity drug

Canadian company awarded world-wide marketing right

On October 1, 1992, Knowell Therapeutic Technologies Inc. announced that the company had signed a 14-year contract with Apotex Scientific Inc. (a member of the Apotex Healthcare Group), to market world-wide the new anti-caries drug, Chlorzoin. Apotex will produce the drug for the world market at its Toronto manufacturing facility.

The drug, which has received patents in eleven countries for its unique chemistry and product efficacy, is a two-stage treatment applied by dental hygienists or dentists. Extensive clinical research and human testing of Chlorzoin indicates a dramatic reduction in oral bacteria known as *mutans streptococci* — a bacteria responsible for between 90 and 95 per cent of all dental caries in children and young adults.

"What makes Chlorzoin different than any other therapeutic treatment for the prevention of cavities is its sustained release. A single, two-stage topical treatment can control the cavity-causing bacteria for six months or more," said Ross Perry, Knowell's President. "The application only takes about 20 minutes, involves no pain, and has not produced any side-effects whatsoever," added Perry.

In a related five-year study it was found that reducing *mutans streptococci* in parents decreased both the bacteria count in their children (transmitted from their parents) and the incidence of cavities. This suggests that reduction of the bacteria in parents, in particular mothers, may also be a preventive measure in the control of cavities in children.

Chlorzoin was developed in the mid-80's by the Faculty of Dentistry, University of Toronto, led by the Head of Microbiology, James Sandham, DDS, PhD.

Knowell Therapeutic Technologies is applying for New Drug Status in several European countries and hopes to receive final approval from the Canadian regulatory authorities in 1993 to market the drug in Canada. Following initial submissions to the United States Food and Drug Administration (FDA), Knowell expects to obtain approval in that country in 1994/5.

The drug is designed to be administered at the time of routine professional dental hygiene prophylaxis and is expected to be at an equivalent cost to the patient.

Canadian Dietetic Association

Innovative, enthusiastic, visionary ... these are the adjectives to describe Sandra Matheson, President of The Canadian Dietetic Association for the 1992-93 term.

Sandra believes that if we are to enable Canadians to live longer in good health then it is essential that national health professional associations work in partnership among themselves and with governments, the private sector and communities to make this vision a reality.

Sandra brings a wide range of experience and expertise to this position of President. She began her career in dietetics in public health in New Brunswick, following the completion of a Bachelor of Science (Home Economics) at Mount Allison University, and a Master of Science in nutritional biochemistry at the University of Toronto. Sandra then joined Beaver Foods Limited as executive nutritionist and initiated a high profile nutrition awareness program for school, college

and industry food services. In 1981, Sandra moved on to join a facility design consulting firm and developed her expertise in food equipment and production systems. Most recently, she launched Matheson Food Management Consultants Ltd., providing consulting services in health care, educational and corporate settings.

Sandra has always been active in her professional associations, and has held many leadership roles, including president of the Ontario Dietetic Association in 1981-82. In recognition of her achievements and contribution to the profession, the Canadian Dietetic Association granted her a Charter Fellowship in 1989.



SANDRA MATHESON



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Canadian Dental Hygienists Association

Community Health Audiovisual Aid Library Acquisitions

In 1989, Pfizer accepted an invitation to become the corporate sponsor for a project to be undertaken by the Canadian Dental Hygienists Association to better enable the dental hygienist to actively initiate and participate in oral health education of the public and health professional groups as a means of health promotion. It was felt that the dental hygienist might be more eager to initiate oral health education for health professional groups and the public if there were available a source of easy to access audiovisual aids (AVA) that would facilitate such activities. Therefore CDHA is proud to present the beginning of this library with the availability of the following packages, manuals and videos all relating to last year's National Dental Hygiene Campaign Focus on "The Older Adult". In addition, CDHA would like to thank Laura MacDonald for her contribution to the creation of this library.

Packages Available:

I "Oral Health in the Elderly: A Workshop Curriculum and Teacher's Guide" produced by the University of Iowa is a package (a slide/script & 2 videotapes with handouts) designed to guide presenters through the process of conducting a workshop for care givers of the elderly. The content includes information on how oral health problems can adversely affect overall health and well-being of the elderly. Presented in case study format, also teaches the caregiver how to recognize oral/dental problems and take appropriate action. A section is provided on talking strategies for the facilitator, as well as suggestions for workshop format. Even the individual who is unfamiliar or inexperienced as a facilitator would feel quite confident in conducting this workshop. Reference materials available to purchase to augment

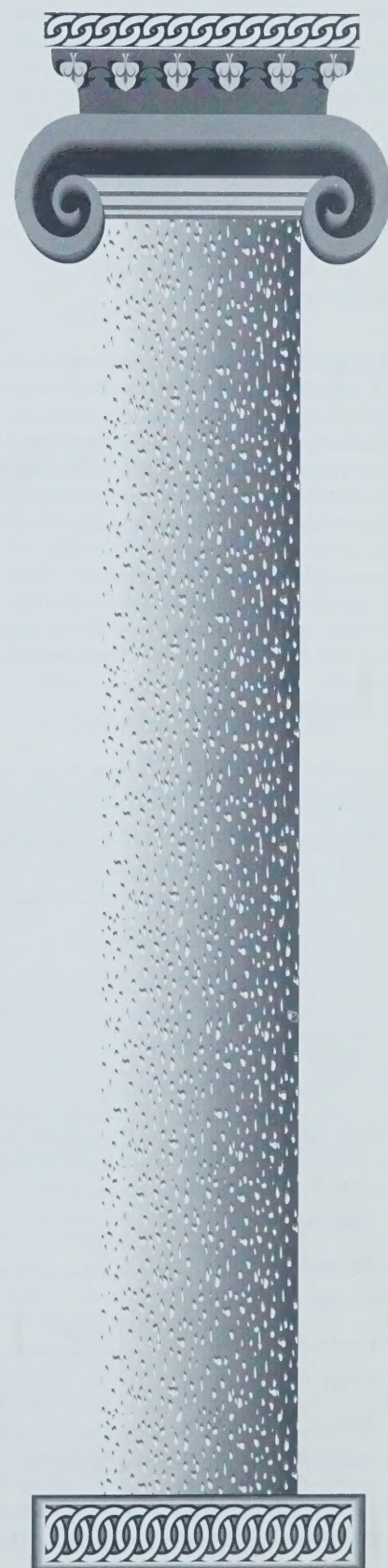
the workshop are listed in the guide. (two available)

II "Oral Health Education for the Elderly... A New Preventive Dental Care Program" produced by the University of Washington, includes lesson/presentation objectives, learning activities and accompanying slide/tape and VHS videocassettes on oral health for the elderly. Topics discussed are detection and prevention of oral disease with emphasis on nutrition. A good resource for both the inexperienced and veteran presenter. (one available)

III "Training and Motivational Materials in Geriatric Dentistry", produced by The University of Mississippi. Good material for interdisciplinary oral health education, such as for nurses, care givers and other professional groups servicing the elderly, as well as the elderly themselves. It discusses how to conduct oral assessments, identify problems, make referrals, and motivate elderly persons to seek needed professional help. It includes two videotapes "Oral Assessment of the Elderly Patient (15 minutes)" and "Common Oral Conditions in the Elderly (40 minutes)", a reference guide with coloured photographs illustrating oral lesions in the elderly, as well as brochures and a referral form. (one available)

Manuals

IV "Geriatric Oral Health: A Training Manual For Long Term Care Facilities", produced by the Arizona Department of Health Services. It discusses dental problems of the elderly, oral hygiene care and oral assessment. (two available)



V "Assessing the Aging Mouth" is produced by the California Geriatric Dental Health Promotion Project. Information covers intra- and extra-oral examination, the physiological changes associated with aging, as well as pathological conditions that may be present, medication and oral manifestations, nutrition and care of the edentulous mouth. The manual has pictorial and corresponding textual layout. It is good for a reference resource for the presenter, or for distribution to a health professional and caregiver audience (medical terminology). (one available)

Slide-Script Set

VI "Senior Smiles", produced by the Ontario Dental Hygienists' Association is a presentation aimed at promoting optimum oral health for seniors. These slides and accompanying script provide basic resource material to assist oral health care professionals in preparing and organizing their own presentations. A wide range of material has been compiled which can be subdivided into several topics including: healthy tissue, hard and soft tissue changes, diseased oral conditions, oral hygiene, and cosmetic dentistry. It is an excellent resource. (two available)

Videotapes

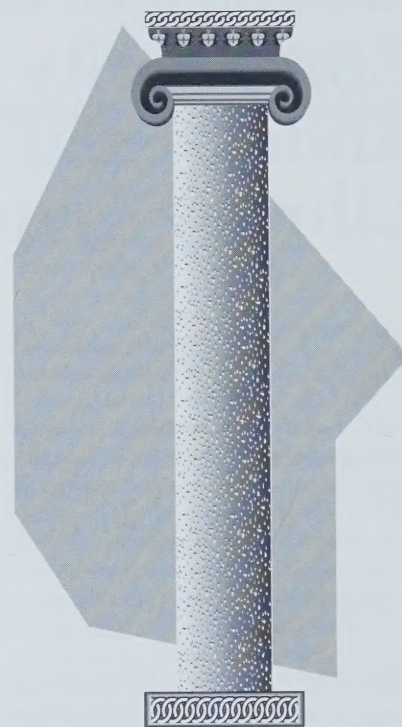
VII "12-Minute Videotape (VHS) For The Elderly", produced by Laval University. Information highlights denture care, choice of toothbrushes and soft tissue oral hygiene. There is also discussion on xerostomia. It is only available in French. (two available)

VIII "Options: Dental Health in Later Years", (15:48 min.) is a American Dental Association Production videotape (VHS). Discussing the progression of periodontal disease (including signs and symptoms), the role of plaque in periodontal disease development and caries (dental and root), oral hygiene, diet and fluoride use. It presents a bleak picture based on statistics. (two available)

IX "The Senior Smile", (14:05 min.) is an American Dental Association Production videotape (VHS) discussing oral hygiene for retirement home residents (dentate and edentulous status), as well as examination for oral lesions. (two available)

X "Oral Health and the Elderly", is a series of three scenarios (VHS format, each one approximately 15 minutes in length) on the role of the care giver in recognizing oral

lesions, oral hygiene aids and oral health. Each scenario begins with a one-to-one correspondence between a dental health care worker and a client. This then broadens to a panel discussion between a variety of health professionals on oral health (eg. pharmacist, gerontologist, nurses). (one VHS available)



Canadian Dental Hygienists Association Community Health Audiovisual Aid Library Order Form

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The Problem-Oriented Dental Record:

A key to dental hygiene treatment planning and the problem-solving model for dental hygiene practice.

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Abstract

The problem-solving model for dental hygiene practice requires careful assessment, planning, implementation and evaluation to provide quality dental hygiene care. To facilitate this problem-solving approach, a method of recording information in an organized and highly communicative manner must be established. This paper describes the components of a problem-oriented dental record used by students at the Vancouver Community College and discusses the benefits of using this tool in clinical practice.

Introduction

Dental hygiene practice is conceptualized as a problem-solving process rather than a list of specific tasks. The Working Group on the Practice of Dental Hygiene developed a schematic model (*Figure 1*) to represent this process.¹ Through this same problem-oriented approach, dental hygiene treatment planning is able to identify specific

planned to obtain the specific goals. Approaching dental hygiene treatment planning in this manner eliminates the "one size fits all" plan.

An accurate method of recording information becomes an important tool in planning dental hygiene care. This paper will explain the components of a problem-oriented dental record necessary to effectively move through the process of dental hygiene care. The benefits of a problem-oriented dental record to patients, clinicians, and the dental practice will also be discussed. The problem-oriented record presented in this paper is the one currently used in the dental hygiene program at the Vancouver Community College. Other formats utilizing this approach can be found in the literature.^{2,3,4}

The Problem-Oriented Approach — What Is It?

The problem-oriented approach follows a definitive, analytical thought process. This thought process provides the necessary link between the collection of data and the proposed treatment plan. Often, it is this "link" or analytical interpretation of the results of the assessments and a statement of the results in terms of recognizable problems that is omitted from dental hygiene treatment planning.³ Without this essential interpretation in the form of a problem list, the approach could then be described as being "treatment-oriented".

Components of the Problem-Oriented Dental Record

The problem-oriented dental record (*Figure 2*) contains four main sections: Subjective, Objective, Assessment and Plan. This classical SOAP format has been utilized in hospital settings for decades and is a dynamic method used at Vancouver Community College to assist the clinician in determining the most appropriate course of action for the patient. In certain circumstances, the SOAP may be performed at the end of the treatment and in other cases, the process may be performed at the re-evaluation and/or supportive periodontal therapy appointment.⁵

The problem-oriented dental record is used together with other recording systems such as charting forms, to help dental hygienists practice at the level identified in the *Clinical Practice Standards for Dental Hygienists in Canada*. All aspects of the problem-solving model for dental hygiene practice — assessment, planning, implementation and evaluation — should be addressed in the problem-oriented dental record.

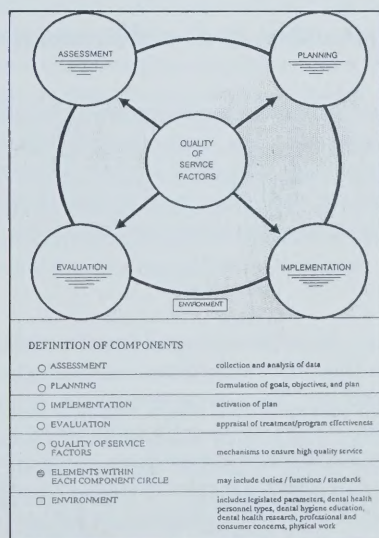


Figure 1. Model for Dental Hygiene Practice¹.

problem areas and provide a rationale for specific treatment modalities. The data obtained through individualized assessments assists the patient and clinician in formulating goals acceptable to both parties. In a feeling of mutual trust and support, collaborative strategies are

Figure 2. Problem-oriented dental record, front.

Figure 2. Problem-oriented dental record, back.

Assessment

The **assessment phase** correlates to the *subjective* data, *objective* data and the *tentative problem list*. The *subjective* data relates to information obtained following an interview. For example, what is the chief complaint and/or complaint? Is there any relevant information which may affect treatment? Are there additional concerns and/or opinions regarding dental health and/or overall wellness?²⁵

The *objective* data relates to information which is collected by the clinician. This data may include abnormal or positive findings utilizing the health history, examinations of the head and neck, intra-oral soft tissue, periodontium and dentition, as well as radiographic findings.

Each item of the *subjective* and *objective* section is systematically reviewed to determine its impact on a potential problem. Having all pertinent or significant findings in one place enables the clinician to formulate a highly resolute problem list. This *problem list* may be prioritized and/or categorized as to whether being a proven diagnosis, symptom, sign, active or inactive problem.² For each problem listed, identification of the etiology and contributing factors involved provides further aid to the clinician in planning the appropriate course of action or treatment plan for dental hygiene services. Figure 3 provides an example of the information found in a problem list.

Problem	Etiology	Contributing factors
localized periodontitis	bacteria	plaque control, smoking overhangs, calculus gingival contour

Figure 3. Problem list.

Planning

With the necessary information recorded, the **planning phase** begins. The planning phase pertains to the formulation of a goal and treatment plan, which is developed in consultation with the patient. The first step is to review the problem list with the patient and discuss the various treatment options available. Possible results of treatment should also be discussed at this time. Once there is an understanding of the present oral health status and the options for treatment, a mutually agreeable goal is identified. The overall *goal* for the patient's problems should be one that is specific, manageable, attainable, realistic and testable. Planning a goal that follows these rules allows for a successful evaluation phase.

The *treatment plan* outlines and prioritizes the services planned for each appointment. For example, a quadrant which exhibits the most significant inflammation and pocket depth would receive a higher priority rating than an area exhibiting light delayed bleeding and minimal pocket depth. If the problem is identified as interproximal bleeding, flossing instruction may be the focus of the first self-care session. In addition to prioritizing and sequencing of services, the treatment plan also identifies the time required for each appointment, the interval between appointments, a plan for evaluation, the cost, recommended referrals, and areas to be monitored.

An important part of the treatment planning process is obtaining consent from the patient. Once the treatment plan has been finalized and agreed to by the patient, the patient signs the problem-oriented dental record. Any change to the original plan requires prior approval from the patient.

Implementation

The **implementation phase** consists of the activation of the plan: treatment and self-care promotion. The problem-oriented dental record guides the clinician through the implementation phase of the dental hygiene process. A continuous record of services provided enables dental personnel to easily identify the treatment completed to date and is an important legal document.

Evaluation

The evaluation phase appraises the effectiveness of the implementation phase in successfully obtaining the specified goal(s). The data used for the initial treatment plan is re-assessed and a new plan for action is developed. The process of care comes full circle and continually strives to address the needs of the patient as an individual. For example, the evaluation phase will determine if the treatment should continue with Phase I Therapy (Periodontal Therapy/Initial Therapy/Etiotropic Phase) or be directed to Phase II (Surgical Phase), Phase III (Restorative Phase) or Phase IV (Maintenance Phase).⁶

Benefits of a Problem-Oriented Dental Record

Health assessment records are indispensable in establishing a dental hygiene treatment plan. The information will determine the treatment needed and provide a baseline to which future results can be compared.⁷ There are many advantages to working with a problem-oriented dental record when designing a treatment plan.

Clinician

For the clinician, the problem-oriented dental record clearly defines problem areas and highlights many of the contributing factors associated with those problems. The assessment data provides rationale for specific treatment in some cases, or the rationale for no treatment in other cases. An example of a situation where a treatment modality is not indicated is the case where a regular maintenance patient presents with no stain and minimal plaque deposits. In this case, a rubber cup prophylaxis is not indicated. Thorough assessment data also helps to distinguish between patients appropriate for a maintenance program and those requiring active periodontal treatment. The emphasis is placed on evaluating tissue response, instead of evaluating calculus removal. Establishing such differences helps clinicians to maximize time utilization and reduce frustration, thereby enabling clinicians to stay "on schedule".

Patient

The problem-oriented dental record benefits the patients by clearly defining the specific problem areas as well as confirming areas of health. Patients need to hear the positive side of their status for encouragement in their current efforts. Discussing their status helps the patient become an active participant in the process by allowing them to formulate their own goals and therefore, establish ownership of the problems and solutions. The problem-oriented dental record provides a basis for open discussion about treatment, untangles complex cases by reducing concerns to individual problems, and helps patients in terms of understanding the problems by eliminating the mystery and/or surprise of multiple appointments. Through this active participation, the patient can develop increased trust in the clinician and the practice.

Practice

There are many advantages to a practice operating with a problem-oriented dental record. The ability to coordinate treatment and effectively utilize the time of the dentist, dental hygienist, and dental assistants is enhanced. The same is true in communication with a referral dentist or medical office. Effective communication is important to prevent omissions of required services and to insure that the patients do not get lost in the "system".

Additional benefits of a problem-oriented dental record include the ease with which information could be used for chart audits, research purposes, and the opportunities available for peer review. In the educational system, the problem-oriented dental record provides an excellent vehicle for faculty members to evaluate the knowledge level of student clinicians and for students to integrate theory into clinical practice.

Conclusions

The problem-oriented dental record is a valuable tool for patient care, communication, audit and education, and is an example of a record keeping system that facilitates a problem-oriented approach in dental hygiene treatment planning. Furthermore, it encompasses the problem-solving process and schematic model developed by the Working Group on the Practice of Dental Hygiene, and as identified in the *Clinical Practice Standards for Dental Hygienists in Canada*. The four phases — assessment, planning, implementation and evaluation — are clearly incorporated into the problem-oriented dental record which can provide dental hygienists with efficient and effective means to assist patients in achieving optimal oral wellness.

References:

1. Health and Welfare Canada. **The Practice of Dental Hygiene in Canada: Description Guidelines and Recommendations. Report of the Working Group on the Practice of Dental Hygiene.** Part One. Minister of Supply and Services Canada, Ottawa, 1988: 86-91.
2. Tryon, A., Mann, W. and DeJong, N. Use of a problem-oriented record in undergraduate dental education. **Journal of Dental Education** 40:9; 601-607, 1976.
3. Ingber, J.S. and Rose, L.F. The problem-oriented record: clinical application in a teaching hospital. **Journal of Dental Education** 39:7, 472-482, 1975.
4. Woodall, I. et al. **Comprehensive Dental Hygiene Care**, 3rd edition. C.V. Mosby Co., St. Louis, Missouri, 72-73, 337-351, 1989.
5. Dental Hygiene Department, **Dental Hygiene Program Policies and Procedures Manual**. Vancouver, Vancouver Community College, 1991.
6. Carranza, F. **Clinical Periodontology for the Dental Hygienist**. W.G. Saunders, Philadelphia, 1986.
7. O'Hehir, T. Planning treatment...from px to tx. **RDH: The National Magazine for Dental Hygiene Professionals**, 18-21, July/August 1984.



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LINDA MASCHAK, RDH

A Literature Review

Oral Irrigation Therapy

The Adjunctive Roles For Home And Professional Use

By: Marsha Stein, RDH

A Literature Review

In the last 10 years especially, research has indicated that oral irrigation can enhance conventional periodontal treatment modalities. Clinicians are eager to include effective techniques which will assist them and their patients in the prevention and care of periodontal infections and maintenance of a healthy periodontium.

This article will consider the literature with respect to the rationale, efficacy, safety and ease of use of mechanized pulsed irrigation for professional and home utilization in adjunctive roles of hygiene or treatment.

An irrigator is a device that uses pressure to flush or deliver a solution to local areas, usually consisting of a reservoir, pump and motor with extended flexible tubing ending with a delivery tip. Manually, irrigation can be performed using a syringe or bulb fitted with a blunt hypodermic needle.

Mechanized, pulsed oral irrigation was first introduced in the mid 1960's. At that time various studies evaluated the ability of irrigation to effectively remove supragingival plaque and debris safely.^{1,2,13,14} More recently, because of a new understanding of plaque bacteriology and factors associated with plaque pathogenicity, investigations have shown that water irrigation is useful in altering the subgingival loosely attached plaque, both quantitatively and qualitatively.^{3,15} With the advent of effective antimicrobial agents, already shown to significantly lessen existing plaque and gingivitis,^{4,5} researchers have investigated their adjunctive use as irrigating solutions. Studies show the efficacy of these medicaments is enhanced to include reductions in suspected periodontopathic, subgingival bacteria.^{6,7} There has been great interest in these findings due to the inability of conventional supragingival methods to significantly affect the subgingival microflora. Manual toothbrushing and rinsing are capable of accessing 1-3mm subgingivally while supragingival irrigation reaches 4-5mm into periodontal pockets.^{8,9,10} Special irrigation attachments and tips have been developed to facilitate clinicians and patients in site-specific subgingival delivery of therapeutic solutions. The limitations of skilled scaling and root planing must be considered too. It has been noted that with scaling and root planing alone or combined with flap surgical procedures, the probability of leaving residual calculus increases with deeper pocket depths.^{11,12}



MARSH STEIN, RDH

Rationale

For many years mechanized oral irrigation has been advocated as having a minimal advantage, at best, to essential plaque control procedures. The outdated "non-specific plaque hypothesis" considered all plaque a homogeneous mass with only the quantity of the plaque being detrimental. However, in the last 10 years, research has indicated that the primary cause of periodontal infections is specific bacterial activity.^{16,17,18,19} Investigators have determined that although several hundred types of microbiota may habitate the oral cavity, only a few singly, or in combination, are responsible for periodontal tissue destruction.²⁰ This newer concept, "specific plaque hypothesis" emphasizes the importance of the plaque and its bacterial ecology. This theory recognizes that certain bacteria are associated with various types and stages of periodontal diseases.

The pathogenicity of plaque may vary from one person to another and even from tooth to tooth within that person.²¹ This results in individuals exhibiting various host responses related to their own immunology. At healthy sites, the gram-positive, aerobic organisms such as streptococci predominate. In periodontitis, the disease-associated microflora are generally gram-negative; anaerobic strains found in the deeper subgingival plaque and the layer of loosely attached plaque which lies in direct contact with the junctional epithelium. These bacteria are of greatest concern since they are in a relatively inaccessible position and may initiate disease²² and be most toxic to the host.²³ Some bacteria species which have been identified as periodontal pathogens are porphyromonas gingivalis (bacteriodes gingivalis) and prevotella intermedia (bacteriodes intermedias) associated with adult periodontitis and actinomyces actinomycetemcomitans, which may prove to be the principal microorganism responsible for juvenile periodontitis⁷³.

However, research has demonstrated that to prevent the progress of periodontal disease, control of supragingival plaque and the repeated disruption of the subgingival microflora is essential. States Dr. Ken Korman: "although supragingival plaque appears to be essential for the development of periodontitis-associated microflora, the supragingival plaque may play a less critical role, once the subgingival ecosystem is established".²⁴ Observations reveal that the most efficient supragingival plaque control techniques cannot eradicate this subgingival flora.²⁵ For several years, mechanized irrigation was studied for its effects on

supragingival plaque only. The variable clinical improvements were sometimes attributed to quantitative reduction of plaque and sometimes to the qualitative alterations in plaque ecology.^{2,26,27,28}

In 1975, Dr. Thomas Tempel conducted a study which examined fractions of solution that irrigation removed after brushing and flossing by comparing volumes of soluble and insoluble matter cleared from the

“Gingivitis did not improve in the control group, but in the experimental group... gingivitis decreased in shallow and deep pockets.”

mouth, the expectorate from oral rinsing.¹⁴ The results showed that water irrigation proved to be more effective than oral rinsing in removing particulate debris and soluble bacterial products, regardless of whether the comparison was made before or after toothbrushing and flossing. Researchers have since examined the ability of oral irrigation to qualitatively alter sufficient subgingival microorganisms to create a shift toward health in the plaque mass.

In addition to the intricate role of supra and subgingival plaques, the prevention or treatment of periodontal conditions is further complicated. Recently, a consensus suggests that periodontal diseases progress by recurrent, acute episodes or “bursts” of activity which range in length from a few days to a few months and are interspersed by periods of quiescence.^{29,30}

Supragingival Irrigation — Patient Applied

Supragingival irrigation can be simply defined as irrigation with the point of delivery at or coronal to the gingival margin resulting in some flushing or delivery into the subgingival space. To evaluate the benefits of supragingival powered irrigation as adjunctive home therapy, attention must be focused on several areas — efficacy, safety and special-needs patients.

Efficacy

The effects of water irrigation on gingival health have been clearly demonstrated. One significant study which included 155 participants, evaluated the effect of an irrigator on calculus formation.¹³

This study lasted twelve weeks and found that irrigation in addition to brushing and flossing, reduced gingivitis and calculus accumulation by fifty percent over the control group. The quantity of plaque was not affected, suggesting that a mechanized irrigation device has the ability to qualitatively alter the plaque composition, preventing it from calcifying. It may also remove early calculus deposits. The investigator suggested that the gingival health benefits may be due to a change in the pH, bacterial and chemical composition of the plaque. From a smaller group of 39 periodontally-treated patients with good oral care habits, there was a significant improvement in the periodontal index and reduction in calculus and plaque in the irrigator group versus the toothbrushing group.²⁹ One study group reported high satisfaction; a “cleaner feeling.”

More recently, supragingival irrigation therapy has been examined

regarding its influence on subgingival plaques — since the disease-associated flora thrive deep within the gingival crevices, accessing these areas is essential to prevent, or inhibit the periodontal destructive progress. It has previously been established that a mechanized pulsed water stream can access, on average, approximately half the depth of the pockets¹⁰ and adversely effect plaque.^{3,15} A six week study was conducted to evaluate the ability of powered irrigation, at depths up to six millimetres, on various bacteria.³⁴

Gingivitis did not improve in the control group, but in the experimental group, where the participants performed supervised water irrigation five days a week during the study, gingivitis decreased in shallow and deep pockets. As well, the deep pockets exhibited a reduction in spirochettes, motile rods and a count reduced by half in bacteroides melanogeniocus and prevotella intermedia (bacteroides intermedius) in the water irrigation group.¹⁵ Clinically, a reduction in bleeding upon probing was also noted.

Other investigators recently examined sixteen irrigated versus untreated control sites in patients diagnosed with advanced, chronic, adult periodontitis.³⁵ Using both scanning and transmission electron microscopy, the excised periodontal pockets were examined immediately following one irrigation treatment with sterile saline. The irrigated pockets harboured significantly less bacteria than the non-irrigated sites. These results were most apparent up to four millimetres.

Supragingival Irrigation — Medicament Enhancement

With the increasing addition of topical chemotherapeutic agents as an integral component of non-surgical periodontal management to reduce plaque and gingivitis, much attention is focused on determining efficacy of numerous agents and modes of delivery.

Oral irrigation has proved to be superior when compared to rinsing for delivery of antimicrobial compounds.^{36,37,38} Presently, only two mouthrinses have achieved the approval of the council on dental therapeutics of the American Dental Association. They are Peridex®, with the active ingredient chlorhexidine digluconate, and Listerine®, a combination of essential oils. Many researchers have reported an enhanced effect of delivery by irrigation.^{6,36,38}

In one six-month clinical trial T.F. Fleming and co-workers assessed the effect of supragingival irrigation with 0.06% Chlorhexidine gluconate on naturally-occurring gingivitis.³⁸ They evaluated the relative benefit of chlorhexidine irrigation in comparison with chlorhexidine rinsing, water irrigation and normal oral hygiene.

Two hundred and twenty two patients were assigned to the following groups:

- | | |
|---------------------|--|
| <i>Group One:</i> | Irrigation once a day with 300 ml water followed by irrigation with 200 ml 0.06% Chlorhexidine gluconate |
| <i>Group Two:</i> | Twice daily rinsing with 15 ml 0.12% Chlorhexidine |
| <i>Group Three:</i> | Irrigation once a day with 500 ml water |
| <i>Group Four:</i> | Brushing with sodium fluoride toothpaste only, representing normal oral hygiene. |

All participants received a supra and subgingival prophylaxis after the baseline examination. They were examined again at three and six months. Irrigation with 0.06% Chlorhexidine demonstrated the best clinical results showing significant reductions in the gingival index at 48% and bleeding on probing at 36.6%. When compared to the normal oral hygiene group. An enhanced effect of chlorhexidine on gingivitis was noted when the chemical was administered by way of an irrigator as opposed to rinsing where reductions in the gingival index were recorded as 28.7% and bleeding on probing at 15.9%. All percentages noted were from baseline measurements.

Water irrigation also demonstrated less but significant clinical benefits. As demonstrated in a previous study conducted by Brownstein et al³⁷ irrigation with 0.06% Chlorhexidine proved to be an effective means of treating naturally-occurring gingivitis. These studies and others imply irrigation may increase the access of solutions below the gingival margin; improved tissue health may result.

In an investigation done with Listerine mouthwash used at full strength, the examiners compared the results of irrigating with Listerine or with a placebo.⁶ All those who irrigated with either compound demonstrated significant improvements in probing depths and attachment level measurements. However, the subjects, using Listerine also illustrated reduced levels in plaque and gingival bleeding.

These and other medicaments indicate promise as adjuncts to mechanical therapies when applied correctly. Much work continues in this area to determine safety and efficacy for irrigation delivery of agents.

“Certainly, for individuals with compromised manual dexterity, an irrigator represents a means to more easily and advantageously improve their oral hygiene status.”

Safety

When clinicians recommend oral hygiene procedures to patients, safety is a prime concern. Shortly after the first powered irrigator was introduced, studies relevant to safety issues began.¹² Work by Dr. S.W. Bhaskar and co-workers at the U.S. Army institute concluded that pulsed water lavage proved more effective than a bulb syringe for removing bacteria from infected wounds and did not appear to produce a bacteremia.³⁹ The same study indicated that attached gingiva could tolerate in excess of seventy P.S.I. pressure while forces of fifty P.S.I. were acceptable for treating ulcerated areas and wounds. Another early investigation determined that a Water Pik® device could be used by the uninstructed patient without causing damage to oral tissues or restorations.¹³ Lately, an ultrastructural examination of an untreated periodontal pocket immediately following irrigation showed no tissue damage.³⁵ Studies as early as 1969 have been conducted on supragingival irrigation effects regarding bacteremia.⁴⁰ Tamini evaluated bacteria in blood samples of subjects displaying various degrees of periodontal health. The participants who used oral irrigation in addition to toothbrushing, exhibited no greater affinity to bacteremia than those in the toothbrushing group. This significant study demonstrated that transient bacteremias are not necessarily produced by oral irrigating devices.⁴⁰

Certainly, there are concerns regarding the incidence of bacteremia. It is important to note that most bacteremias are random and may be linked to any number of normal oral functions such as masticating and toothbrushing.⁴¹ Since the occurrence relates proportionately to the degree of gingival inflammation, optimal oral health is mandatory for a medically-compromised dental patient. Routine treatment must always be determined on an individual basis. Those people considered “at risk” for infective endocarditis require special attention for all therapies — routine home care, instrumentation and surgical procedures are contraindicated without antibiotic prophylaxis.^{42,43} Patients who have received heart valve or joint replacements, organ transplants or those who have mitral valve prolapse with valvular regurgitation are considered at high risk.

Special-Needs Patients

Certainly, for individuals with compromised manual dexterity, an irrigator represents a means to more easily and advantageously improve their oral hygiene status.^{2,31} Throughout treatment, the orthodontic patient is faced with the arduous task of removing debris from the orthodontic bands and maintaining good oral hygiene. The addition of an oral irrigator to routine toothbrushing shows a significant increase in debridement and improvement in oral hygiene while not damaging orthodontic bands or appliances.^{32,33}

Professionally-Administered Irrigation Subgingival Delivery Of Chemotherapeutic Agents

Subgingival irrigation may be described as intentional localized irrigation of a gingival crevice or pocket.⁴⁴ Much information exists which supports the efficacy of root planing to eliminate subgingival deposits.⁴⁵ However, most therapists fail to totally cleanse root surfaces where probing depths are in excess of five millimetres. Surgical procedures are often required to gain access and still, perhaps, only fifty percent of root surfaces in pockets greater than six millimetres are effectively cleaned.⁴⁶ Areas such as grooves, furcations, and the cemento-enamel junction retained the most residual calculus. Systemic antibiotics can be prescribed to reduce the subgingival flora but extended, or repeated use is not recommended because resistant bacterial strains could develop.⁴⁷ Lately, targeted irrigation with antimicrobial agents is being utilized professionally to help control subgingival bacteria. The status of this therapy for the treatment of periodontitis is still being clarified but holds promise. The incorporation of site-specific pharmacotherapy into treatment and maintenance phases of periodontal treatment must include three factors:⁴⁸

1. Drugs must be delivered to sites of disease activity
2. Antimicrobial needs to be used at bactericidal concentrations
3. Medicaments must be present long enough to work

The ability of professionally administered subgingival irrigation will be considered with respect to efficacy and safety, as well as effects on the composition of the microflora and clinical parameters in periodontitis.

Adjunctive professional irrigation may be used during initial therapy as well as the supportive recall visits to augment scaling and root planing, and between visits to control microflora.

Several scientific reports evaluated the capability of various devices to deliver drugs to the site of disease activity — the base of the pocket.²² In 1982, The Group of Hardy, Newman and Strahan conducted a study designed to compare two direct irrigation techniques for periodontal pocket delivery. With a syringe and blunt hypodermic needle⁴⁹ irrigation with a disclosing solution was performed at the gingival margin or three millimetres within the pocket. The latter method proved to effectively reach the apical plaque border in shallow and deep pockets. The results of this study suggest that deep irrigation may prove to be a suitable approach to effectively control subgingival plaque. A cannula subgingival irrigator tip can deliver medicaments deeper into the periodontal pocket than a standard oral irrigator tip.⁵⁰ This investigation conducted a test on periodontally involved teeth, recommended for extraction. Mean depth of penetration with the cannula tip was 70.4% in medium pockets and 74.5% in pockets greater than 6 millimetres; the standard jet tip compared with 29% and 54.3% respectively. Confirmatory studies indicate similar results^{51,52} and have encouraged research to determine the effects of subgingival irrigation on periodontal status. Mechanized devices which could provide extremely low, consistent pressure were developed to enable professionals to easily and safely deliver drugs directly into periodontal pockets.

In 1985, Kelly and group compared intrasulcular delivery pressures produced by a hand syringe, peristaltic pump, and a powered irrigator fitted with a special handpiece and cannula.⁵³ Only the Water Pik® irrigation device exhibited a force that was considered physiologically acceptable to human periodontal pocket tissues. This information suggests that an oral irrigation device is able to provide a gentle, safe method of placing fluids subgingivally. As well, findings from a study by R.T. Dunkin and his co-workers illustrated that subgingival irrigation delivery with a saline solution was administered safely with no pain or trauma to the subjects.⁵⁴ This study also showed an improvement to the gingival health.

Although subgingival irrigation is a relatively new periodontal therapy, many studies have evaluated its clinical and microbiological benefits. It should be noted that inconsistency in the results may be due to variation in study design factors — frequency of irrigation, chemical agents, duration of trials and parameters investigated as well as types of patients' disease. In a 10-week assessment of patients with chronic periodontitis, subgingival irrigation was performed weekly with either 1.64% Stannous fluoride, 0.4% Stannous fluoride or sterile saline.⁵⁵ Results indicated that 1.64% Stannous fluoride caused a significant reduction in bleeding index scores which correlated positively to a dramatic and sustained decrease in motile bacteria and spirochetes following irrigation. Other evaluations which considered subgingival lavage as a monotherapy have reported an initial decrease in bleeding upon probing.^{56,57}

In conjunction with scaling and root planing, it was possible to achieve pocket reduction of 2 - 3 millimetres.^{58,59} This, in part, may be

due to the fact that scaling and root planing prior to irrigation may illicit better interaction between medicaments and microbes by promoting dispersal of organized plaque.⁶⁰ Clinical and microbiological benefits of irrigation appear to be the greatest when combined with mechanical treatment and performed repeatedly.^{56,61} Improvements in attachment levels with reductions in gingival indices, bleeding on probing and alterations in the subgingival microflora were reported. Various studies have also been conducted to investigate the benefits of professionally-applied irrigation at the periodontal prophylaxis appointment with the addition of adjunctive daily applied marginal irrigation. In an eight week period, a test group of patients classified as exhibiting gingivitis or early periodontitis received one professional subgingival application of stannous fluoride following scaling.⁶² Along with daily flossing and toothbrushing they continued at home with subgingival delivery of an iodine solution. When compared to baseline, this group had significantly lower bleeding and gingival index scores.

When combined with antimicrobial compounds, subgingival irrigation may be especially useful for patients who cannot undergo conventional periodontal therapy, for whom non-surgical procedures are not effective for controlling their periodontal conditions, and for those with refractory periodontal disease to use during maintenance treatment.⁶³ "Lavage therapy is best used by clinicians as a supplemental method when optimal results are not obtained using conventional procedures".⁶⁴

Patient-Applied Subgingival Irrigation

Daily self-administered subgingival irrigation may prove to be an important component of a home oral hygiene program for those patients who cannot maintain periodontal sites which are inaccessible to brushing and flossing.

"The trend suggests that extending the duration of oral irrigation therapy following scaling and root planing results in prolonged suppression of microbes.⁶³ Research data shows that regular episodes of subgingival irrigation over time provide significant clinical and microbiological benefits."^{62,65,67}

However, as with any home care technique, a certain level of dexterity in combination with compliance is necessary to illicit successful results.⁷⁰ In the past, syringes or spray bottles fitted with hypodermic needles were used to provide targeted pocket irrigation. In the early 1980's, a group of periodontal patients participated in a study which was designed to determine if self-applied subgingival irrigation was a viable approach for a safe and effective adjunct in home periodontal maintenance care.⁵⁷ The test group first received scaling and polishing and then instruction in pocket irrigation using a hand syringe and blunt needle. No other oral hygiene instructions were given. After four weeks of daily self-irrigation, it was concluded that the technique itself caused no discernable injury and further with the addition of chlorhexidine, subgingival irrigation proved to be an effective method



in reducing periodontal inflammation and controlling subgingival plaque.

However, it must be mentioned that hand syringes are time consuming to use and unreliable in terms of executing consistent low pressures.⁵³ Improved alternatives are now available. One such device, the Pik Pocket Subgingival Delivery Tip® adapts to the Water Pik® oral irrigator. In a test conducted at the state University of New York at Buffalo, New York, this newly-designed irrigation tip was determined capable of safely delivering an aqueous solution to approximately 80% of the depth of the pocket.⁶⁶ No tissue damage was recorded and participants did not experience any discomfort. Lately, the Pik Pocket Tip was employed in a six-week trial which evaluated the effect of daily subgingival irrigation with Listerine® antiseptic. When compared to the control group, the group irrigating with the test solution exhibited a significantly greater and more sustained decrease in the periodontopathic flora, suggesting that self-irrigation therapy with Listerine antiseptic may be useful as an adjunct to conventional periodontal treatment.

Sixty periodontal maintenance patients were selected for an evaluation with yet another chemical agent — chlorhexidine gluconate. It was clearly demonstrated that with a combination of scaling and root planing, a single professional application and daily home subgingival irrigation, it is possible to achieve significant clinical and microbiological benefits.⁶⁵

Much evidence exists that there is potential for the beneficial effects of subgingival irrigation after termination of treatment.^{57,68,69} Daily subgingival irrigation for approximately four weeks was performed with a variety of medicaments. It has been suggested that benefits like significantly reducing periodontal inflammation and subgingival microflora, might be enhanced and prolonged with efficacious antimicrobial agents.⁶⁸ It is necessary to evaluate the effects of the delivery device separately from the chemotherapeutic agent. All the advantages of subgingival irrigation with chemicals are not yet fully understood. However, this approach provides great potential for improving and maintaining an individual's periodontal status in conjunction with professional supportive therapy.⁶⁵

Summary

It is now recognized that there are several different types of periodontal infections. As we learn more about the cause of these diseases, it becomes obvious that we have treatment options. A successful choice of procedures for each individual depends on an accurate diagnosis based on comprehensive data collection of clinical and microbiological findings. Treatment choices include a non-surgical phase which consists of plaque removal, plaque control, scaling, root planing, and the use of chemical agents.¹ For complete debridement of deep pockets, furcations or areas with root surface irregularities, surgical access may be necessary.^{2,3}

When considering drug therapy, it must be noted that systemic antibiotics may be necessary to suppress those subgingival periodontal pathogens which have the ability to invade the tissue and resist other methods of eradication.⁴ Removal or alteration of pathogenic flora is mandatory to improve a patient's periodontal health. The extensive use of supragingival irrigation as an adjunct for treating gingivitis has led to the interest in subgingival irrigation as a possible adjunct for treatment of periodontal diseases.⁴⁴ Targeted lavage and subgingival delivery of effective antimicrobial agents show potential as supplemental

office procedures or as a component of a home oral hygiene regime.⁵ Additional research is needed to develop more efficacious chemotherapeutic substances than are currently available and to further define the optimum application of each. Substantive medicaments that react specifically against periodontopathic organisms are essential. Exact frequency and duration of professionally-applied and self-administered subgingival irrigation need to be determined for maximum results.

Further investigation is required to establish the potential role of adjunctive irrigation and antimicrobial therapy in the treatment of periodontitis.

Yet, another important application of irrigation has been recognized. Recently, the American Heart Association revised its guidelines for the prevention of bacterial endocarditis. The amendments to the dentistry sections have been approved by the Council on Dental Therapeutics of the American Dental Association. Included in this text is the recommendation that as an adjunct to antibiotic prophylaxis, sulcular irrigation with chlorhexidine may be useful for those patients considered high risk and/or have poor oral hygiene.⁶

"Much evidence exists that there is potential for the beneficial effects of subgingival irrigation after termination of treatment."

Irrigation therapy is undergoing extensive scrutiny in the scientific research community. Presently, considerable conclusive evidence exists to suggest that adjunctive irrigation may play an important role in controlling gingivitis and periodontitis. The overwhelming challenge for any and all successful periodontal therapy will always remain dependent on patient compliance to regular professional and home care.

Acknowledgements

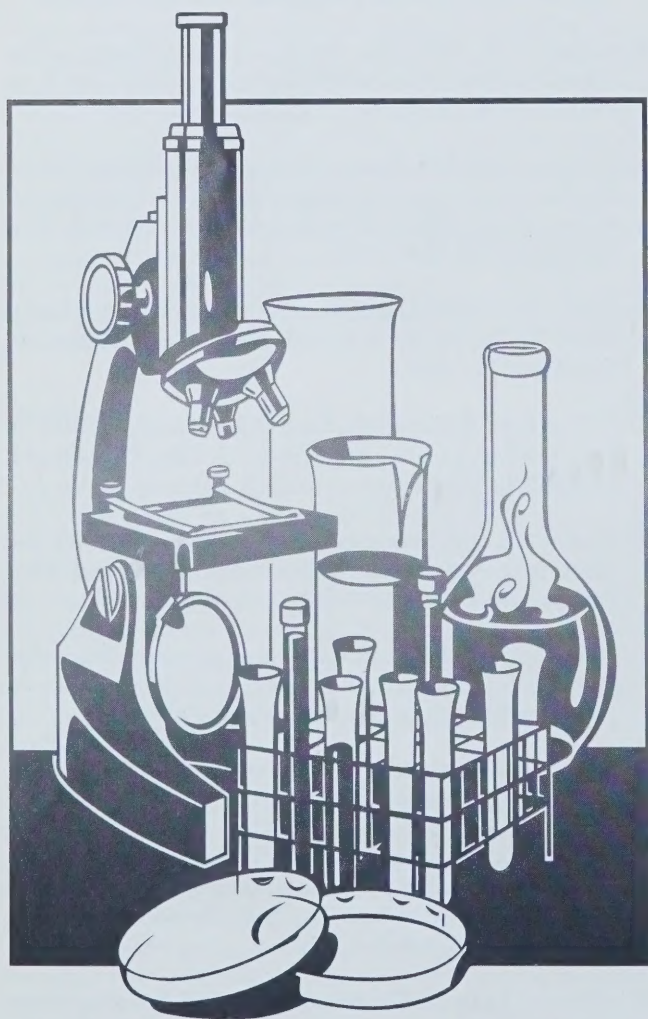
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Bibliography

Oral Irrigation Therapy — The Adjunctive Roles For Home and Professional Use

1. Bhaskar S.N., et al: Water Jet Devices In Dental Practice. **J. Periodontal** 1971. 42:658-664
2. Hoover D.R., Robinson H.B.G.: The Comparative Effectiveness Of The Water Pik Device In A Non-Instructed Population. **J. Periodontal**. Abstr. 1969
3. West B.L.: An Evaluation Of An Oral Irrigating Device's Ability To Reduce The Microbial Count Of Subgingival Plaque At Six Millimetres in Depth, Thesis, University Of Missouri, Kansas City, MO, 1982
4. Axelsson, P. And Lindhe, J: Efficacy Of Mouth Rinses In Inhibiting Dental Plaque And Gingivitis In Man, **J. Clin. Periodontal**, 1987 14:205-212
5. Lamster I,B, et al: The Effect Of Listerine Antiseptic On Reduction Of Existing Plaque And Gingivitis, **Clin. Prevent. Dent.** Vol. 5#6, Nov-Dec, 1983
6. Ciancio S.G. et al: Effect Of A Chemotherapeutic Agent Delivered By An Oral Irrigation Device On Plaque, Gingivitis, AND Subgingival Microflora. **J. Periodontal**, 1989. 60:310
7. Azis-Gandour I.A. et al: The Effects Of A Simplified Oral Hygiene Regime Plus Supragingival Irrigation With Chlorhexidine Or Metronidazole On Chronic Inflammatory Periodontal Disease, **J. Clin. Periodontal** 1986. 13:228
8. Waerhaug, J.: The Interdental Brush And Its Place In Operative And Crown And Bridge Dentistry. **J. Oral Rehabil**, 1976. 33:107
9. Reitman W.B., et al: Proximal Surface Cleaning By Dental Floss **Clin. Prev. Dent.** 1980. 2:7
10. Eakle, W.S. et al: Depth Of Penetration In Periodontal Pockets With Oral Irrigation. **J. Clin. Periodontal** 1986. 13:39
11. Waerhaug 1978: Healing Of The Dento-Epithelial Junction Following Subgingival Plaque Control II: As Observed On Extracted Teeth, **J. Perio**, March, 1978
12. Cafeese Sweeny, et al: Scaling And Root Planing With And Without Periodontal Flap Surgery, **J. Clinical Periodontal**, 1986
13. Lobene, R.R.: The Effect Of A Pulsed Water Pressure Cleansing Device On Oral Health. **Journal Of Periodontal**. 40:51-54, 1969
14. Tempel, T.R. et al: Comparison Of Water Irrigation And Oral Rinsing On Clearance Of Soluble And Particulate Materials From The Oral Cavity. **J. Of Periodontal**, Vol. 46 #7, 1975
15. Aday, J.B.: An Evaluation Of An Oral Irrigation Device's Ability To Quantitatively Reduce The Bacterial Count Of Spirochettes Filaments, Fusiforms And Motile Bacteria From Subgingival Plaque; A Thesis In The Department Of Periodontics; University Of Missouri — Kansas City, 1982
16. Socransky, S.S.: Microbiology Of Periodontal Disease — Present Status And Future Considerations. **J. Periodontal**. 48-497, 1977
17. Page, R.C., And Schroeder, H.E.: Pathogenesis Of Inflammatory Periodontal Disease. **Lab Invest**. 33:235, 1976
18. Listgarten, M.A., And Hellden, L.: Relative Distribution Of Bacteria At Clinically Healthy And Periodontally Diseased Sites In Lomans, **J. Clin. Periodontal**. 5:115, 1978
19. Newman, M.G.: Current Concepts Of The Pathogenesis Of Periodontal Disease — Microbiology Emphasis. **J. Periodontal**. 53:734, 1985
20. Williams, R.C.: "Periodontal Disease" **New England Journal Of Medicine** Vol. 322 (1990):373-382
21. Lindhe, J., et al: Some Microbiological And Histopathological Features Of Periodontal Diseases In Man. **J. Clin. Periodontal**. 51:264-269, 1980
22. Carranza, F.A. Jr., Glickman's Clinical Periodontology Philadelphia: W.B. Saunders Co. 1979 386-388
23. Fine, D.H. et al: Studies In Plaque Pathogenicity "Plaque Collection And Limulus Lysate Screening Of Adherent And Loosely Adherent Plaque" **J. Clin. Periodontal**. Res. 13:17-23, 1979
24. Korman, K.S.: "The Role Of Supragingival Plaque In The Prevention And TREATMENT Of Periodontal Diseases, **J. of Perio**. Research Supplement; 5-22, 1986
25. Tabita, P., et al: Effectiveness Of Supragingival Plaque Control On The Development Of Subgingival Plaque And Gingival Inflammation In Patients With Moderate Pocket Depth. **J. Clin. Periodontal**, 52:88-93, 1981
26. Brady, J.M., et al: Electron Microscopic Study Of The Effect Of Water Jet Devices On Dental Plaque. **J. Dent. Research**. 52.6:1310-1313, 1973
27. Lobene, R.R.: A Study Of The Force Of Water Jets In Rekatuib To Pain And Damage To Gingival Tissues. **J. Clin. Periodontal**. 41:166-169, 1971
28. Hoover, D.R. et al: The Comparative Effectiveness Of A Pulsating Oral Irrigator As An Adjunct In Maintaining Oral Health. **J. Clin. Periodontal**. 42:166-169, 1971
29. Socransky, S.S. Haffajee, A.D., et al: New Concepts Of Destructive Periodontal Disease In Adult Subjects In The Absence Of Periodontal Therapy. **J. Clin. Periodontal**. 10:433, 1983
30. Lidhe, J., Haffajee, A.D., et al: Progressions Of Periodontal Therapy. **J. Clin. Periodontal**. 10:433, 1983
31. Isshiki, Yasushige, Tokyo Dental College, Tokyo, Japan. Effects Of Oral Cleansing In Cerebral Palsied Children. **BULL, Tokyo Dent. Coll.** 11:121-131, 1971, From Dental Abstracts, A Publication Of The A.D.A.
32. Callander, David D.: The Effectiveness Of A Pulsating Water Device In Removing Oral Debris From Orthodontic Patients.

33. Hurst, J.E. And Madonia, J.V.: The Effect Of An Oral Irrigation Device On The Oral Hygiene Of Orthodontic Patients. **J.A.D.A.** 81:678-682, 1970
34. White, C.L. et al: The Effect Of Supervised Water Irrigation On Subgingival Microflora. I.A.D.R. Abstr., 1988
35. Cobb, C.M., Rodgers, R.L., Killoy, W.J.: Ultrastructural Examination On Human Periodontal Pockets Following The USE Of An Oral Irrigation Device In Vivo. **J. Periodontal**, 1988
36. Lang, N.P. Raber, K. "Use Of Oral Irrigations As Vehicle For The Application Of Antimicrobial Agents In Chemical Plaque Control. **J. Clin. Periodontal**, 8:177-188, 1981
37. Brownstein, C.N. et al: Irrigation With Chlorhexidine To Resolve Naturally Occurring Gingivitis. A METHODOLOGIC Study; **J. Clinical Periodontal**. 17:558:593, 1990
38. Flemming, T.F. et al: Supragingival Irrigation With 0.06% Chlorhexidine In Naturally Occurring Gingivitis; **J. Periodontal**. 61(2):112-117, February 1990



39. Bhaskar, S.N. et al: Effect Of A High Pressure Water Jet On Oral Mucosa Of Varied Density. **J. Periodontal**. 40:35-49, 1969
40. Tamini, H.A. et al: The Role Of The Water Pik® Device In Bacteremia; **J. Periodontal**. 40:424-426, 1969
41. Pallasch, T.J.: A Critique Of Antibiotic Prophylaxis, **California Dental Association Journal**, 1986
42. Silver, J.G. et al: Experimental Transient Bacteremias With Varying Degrees Of Plaque Accumulation And Gingival Inflammation, **J. Clin. Periodontal** 4:92-99, 1977
43. Sconyers, J.R. et al: Relationship Of Bacteremia To Toothbrushing In Patients With Periodontitis, **J. AM. Dental Association**. 87:616-622, 1973
44. Goodman, C.H., Robinson, P.J.: Periodontal Therapy — Reviewing Subgingival Irrigations And Future Considerations, **J. AM. Dental Association**, Vol. 121:541-543, October, 1990
45. O'Leary, T: The Impact On Research On SC. And R.P., **J. Periodontal**. 14:425, 1986
46. Robbani, G. et al: The Effectiveness Of Subgingival SC. And R.P. On Calculus Removal, **J. Periodontal**. 52:119, 1981
47. Van Palenstein, Helderman, W.H; Is Antibiotic Therapy Justified In The Treatment Of Human Chronic Inflammatory Periodontal Disease? **J. Clin. Periodontal**. 13:932, 1986
48. Goodson, J.M.: Controlled Drug Delivery: A New Means Of Treatment Of Dental Diseases. **Compend. Cont. Educ. Dent**. 6:27, 1985
49. Hardy, J.H., Newman, H.N. And Strahan, J.D.; Direct Irrigation And Subgingival Plaque, **J. Clin. Periodontal**. 9:57-65, 1982
50. Hollander, R. et al: Comparison Of Cannula Versus Standard Jet Tip For Oral Irrigation, **J. Dent. Res.** 68:410, 1989 (Abstract 1829)
51. Dunkin, R.T. et al: An Effectiveness Study Of A Subgingival Delivery System, **Quint. Int.**, 20(5):345-346, 1989
52. Larner, J.R., M.S. Thesis, Dept. Of Periodontics, Northwestern University, 1988
53. Kelly, A. et al: Pressures Recorded During Periodontal Pocket Irrigation. **JE. Periodontal**. 56(5):297-299, MAY 1985
54. Dunkin, R.T. et al: Safety Study Of A Subgingival Delivery System; **Quint. Int.** 20(6):401-402, 1989
55. Mazza, J.E. et al: Clinical And Antimicrobial Effect Of Stannous Fluoride On Periodontitis. **J. Clin. Periodontal**; 8:203-212, 1981
56. Southard, S. et al: The Effects Of 2% Chlorhexidine Digluconate Irrigation On The Levels Of Bacteroides Gingivalis In Periodontal Pockets. **J. Periodontal**. 60:302, 1989
57. Soh, L. et al: Effects Of Subgingival Chlorhexidine Irrigation On Periodontal Inflammation. **J. Clin. Periodontal**. 9:66, 1982

58. Braatz, L. et al: Antimicrobial Irrigation Of Deep Pockets To Supplement Non-Surgical Periodontal Therapy. II DAILY Irrigation. **J. Clin. Periodontol.** 12:630, 1985
59. Mac Alpine, R. et al: Antimicrobial Irrigation Of Deep Pockets To Supplement Oral Hygiene Instruction And Root Debridement; I. Bi-Weekly Irrigation. **J. Clin. Periodontol.** 12:568, 1985
60. Greenstein, G.: Subgingival Irrigation — An Adjunct To Periodontal Therapy. Current Status And Future Directions. **J. Dental Hygiene** 389-397, October 1990
61. Silverstein, L. et al: Clinical And Microbiological Effects Of Local Tetracyclines Irrigation On Periodontitis. **J. Periodontol.** 59(5):301-305
62. Wolff, L.F. et al: The Effects Of Professional And Home Subgingival Irrigation With Antimicrobial Agents On Gingivitis And Early Periodontitis; **J.D.H.**, 63(5):222-241, JUNE, 1989
63. Wilkins, E.M.: Clinical Practice Of The Dental Hygienist, Sixth Edition, Philadelphia Lea And Febiger, 1989
64. American Academy Of Periodontology: Proceedings Of The World Workshop In Periodontics, Non-Surgical Treatment; Consensus Statement 11-13, 1989
65. Jolkovsky, D.L. et al: Clinical And Microbiological Effects Of Subgingival And Gingival Marginal Irrigation With Chlorhexidine Glauconite. **J. Periodontol.** 61(11):663-669, Nov. 199
66. Braun, R.E. et al: Subgingival Delivery By An Oral Irrigation Device, **J. Periodontol.** 1992; 63:469-472
67. Harper, D.S. et al: Effect Of Subgingival Irrigation With An Antiseptic Mouthrinse On Periodontal Pocket Microflora, I.A.D.R. Abstract #474, SPT. 1991
68. Macaulay, W.J.R. et al: The Effect On The Composition Of Subgingival Plaque Of A Simplified Oral Hygiene System Including Pulsating Jet Subgingival Irrigation. **J. Periodontal Res.** 21:375-385, 1986
69. Wan Yusof, Z.A. et al: Subgingival Metronidazole In Dialysis Tubing And Subgingival Chlorhexidine Irrigation In The Control Of Chronic Inflammatory Periodontal Disease. **J. Clin. Periodontol.** 11:166-175, 1984
70. American Academy Of Periodontology: Proceedings Of The World Workshop In Clinical Periodontics. Chicago: **American Academy Of Periodontology.** 1989:11, 1-11 .21
71. Brayer, W.K. et al: Scaling And Root Surface Effectiveness: The Effect Of Root Surface Access And Operator Experience. **J. Periodontol.** 1989 - 60, 67, 72
72. Sherman, P.R. et al: The Effectiveness Of Subgingival Scaling And Root Planing. Clinical Detection Of Residual Calculus. **J. Periodontol.** 1990, 61:3-8
73. Christersson, I.A. et al: Tissue Localization Of Actinobacillus Actinomycetemcomitans In Human Periodontitis. Light Immunofluorescence And Electron Microscopic Studies. **J. Periodontol.** 1987 58-540-5
74. Greenstein, G.: Subgingival Irrigation — An Adjunct To Periodontal Therapy. Current Status And Future Directions. **J. Dent. Hygiene**, Oct. 1990:389-396
75. Dajani, A.S. et al: Prevention Of Bacterial Endocarditis. Recommendations By The American Heart Association **J.A.M.A.**, Dec. 1990, Vol. 264 #22

ANTI-PLAQUE **Viadent**[®]

HORNER
Montreal, Canada

Sanguinaria Extract
Anti-Plaque/Anti-Gingivitis Preparations

INDICATIONS: Adjunctive treatment for the maintenance of good oral hygiene, control of dental plaque and the reduction and inhibition of gingivitis.

CONTRAINDICATIONS: Other than hypersensitivity to Viadent or one of its components, there are no contraindications to the use of this product.

PRECAUTIONS: It is possible that Viadent Anti-Plaque preparations may interact chemically with other orally applied drugs, although no such drug interactions have been reported to date. Routine swallowing of the product is not recommended.

Staining of dental restorations does not appear to be a problem with Viadent preparations. In laboratory testing with the rinse, only one light-cured composite, Durafil-Kulzer, was slightly yellowed after immersion in the rinse for 24 hours.

Use of Viadent Anti-Plaque preparations is not recommended in pediatric oral health programs due to the alcohol content in the rinse and for the toothpaste, when caries is the principal dental disease and for which a fluoride product is indicated.

The safe use of Viadent Anti-Plaque preparations during human pregnancy and lactation has not been established. As with any drug, use during pregnancy or lactation requires that the expected therapeutic benefit of the drug be considered against the unknown risks to the mother, foetus or neonate.

DOSAGE AND ADMINISTRATION: Viadent Anti-Plaque Oral Rinse: Administer after brushing morning and evening. Rinse twice consecutively using 15 mL per rinse for 15 seconds each time.

Viadent Anti-Plaque Toothpaste: Administer as a ribbon of paste on a toothbrush morning and evening.

SUPPLIED: Viadent Anti-Plaque Oral Rinse: Bottles of 500 mL.
Viadent Anti-Plaque Toothpaste: Tubes of 50 mL, 100 mL.

Alternatives in Dental Hygiene Practice

By: Jackie Smorang, BA, RDH, MSED

Introduction

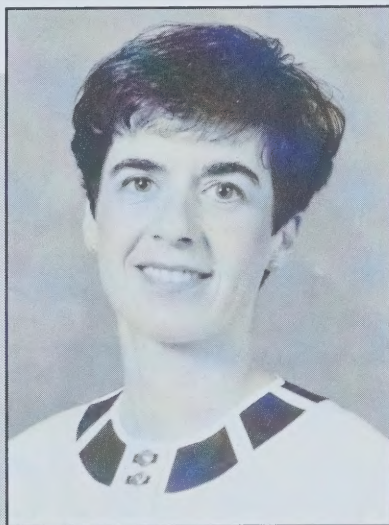
The profession of dental hygiene has given me the opportunity to experience a variety of work settings. Since graduating from the University of Manitoba in 1975, I have worked in private practice, dental assisting and hygiene education, public health, health promotion, and most recently, hospital dentistry.

Hospital Dentistry

I am presently employed by the Division of Oral Medicine at Foothills Hospital in Calgary. Foothills Hospital is southern Alberta's university hospital and the regional referral, teaching and research centre. The Division of Oral Medicine's mandate is "to provide definitive quality dental care for the mentally and physically handicapped, medically compromised and geriatric patient; to enhance their quality of life and function and to minimize any disease related complications."

As an outpatient clinic, the majority of our patients are referred by their physician or dentist. Our current patient population is quite different from the average private practice. The handful of patients who may disrupt your daily clinical routine because of behaviour and medical problems, are our regular patients.

Approximately thirty per cent of our patients are mentally and/or physically challenged and often require some type of physical or chemical restraint (with consent). Another thirty per cent of our patients have some type of infectious agent known to be carried in the blood or saliva. These patients include those with HIV, hepatitis and tuberculosis. Twenty per cent of our patients have cancer that affects the oral cavity. Most of these patients have had head and neck cancer, and may have received extensive oral pharyngeal surgery and radiation therapy. The rest of our patients have some other medically compromising conditions which



JACKIE SMORANG, BA, RDH, MSED

may include: severe cardiac and/or pulmonary problems, renal failure, stroke, cerebral palsy, multiple sclerosis, seizure disorders, transplants and dementia.

The clinical dental hygiene procedures I provide for our patients are no different than in private practice. However, it is often necessary to treat patients in a wheelchair or transfer them to a dental chair. Since our patients' oral health is usually complicated by their medical problems, the oral care instruction I provide needs to be modified because of the patients' various limitations.

I am usually asked two questions when my friends and peers learn where I work. The first question is: "How do you treat your infectious patients?" My answer is: "We treat everyone the same whether he/she is healthy or not because the clinic adheres to Universal Precautions." The second question often asked is: "Are you afraid when working on high risk patients?" My response: "I am aware of our patients' complete medical histories which may not be disclosed in other dental offices and I am confident in the staff and the support our facility has to offer."

In addition to my clinical responsibilities, I have been involved in education and research activities at the hospital. Working with the Nursing Department, a Mouthcare Protocol was established and implemented for the patients. In-services were presented to the staff to assist them when performing mouthcare procedures. In 1992, I received a CFDE fellowship, sponsored by Warner-Lambert Canada Inc., to conduct a research project to determine mouthcare knowledge, attitudes and practises of care providers in an extended care facility. The survey results will assist in developing appropriate educational strategies and relevant oral health sessions for the facility staff.

Conclusion

The unique situation at Foothills Hospital has allowed me to utilize my clinical, educational and research skills plus contributed to my professional growth and development. The variety of workplace settings that I have experienced over the years, has continually challenged me in my profession of dental hygiene.

J. Smorang represents CDHA on the CDA Committee on Institutional and Community Dentistry and reports to CDHA through the Practice & Regulation Council.

Abstracts

Part two of a selection presented by Canadian dental hygienists at the 12th International Symposium on Dental Hygiene

Whose career is it anyway?! — A case study with political implications relative to the education and licensure of dental hygienists in British Columbia.

F.R. Cotton, RDH, Chair: Division of Dental Studies, College of New Caledonia, Prince George, British Columbia, V2N 1P8.

In 1986, following a history of only one educational program for dental hygienists in the province, the British Columbia Ministry of Advanced Education established a second Dental Hygiene Program in the northern city of Prince George. Prior to the establishment of this program there was an acute shortage of dental hygienists in the region and many were being recruited from the United States and neighbouring Alberta. The program was accredited nationally; however, the provincial licensing body which controlled the graduates' right to practise refused to grant the program parity with the established program in the southern and more populated region of the province and with programs from other parts of the country.

This case study outlines the historical, political and socio-economic factors that contributed to the eventual recognition of the program in 1991, and the acknowledgement that dental hygienists have a right to participate in their own educational process.

A workshop approach to enhancing quality of dental hygiene care

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Clinical Practice Standards for Canadian Dental Hygienists were established in 1988 as part of the work of the federal government Working Group on the Practice of Dental

Hygiene. During 1989-90, the Canadian Dental Hygienists Association developed a quality assurance workshop package which allows individual dental hygienists to assess their professional clinical practice against the Practice Standards. This workshop approach to quality assurance is an educational, self-directed, non-threatening strategy which has been well received by Canadian dental hygienists.

This paper will review:

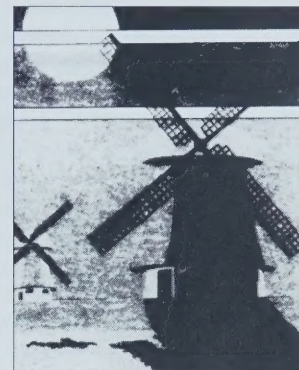
1. The development of the Clinical Practice Standards;
2. The enabling role played by the national association in developing the workshop package, which focuses on the role of the dental hygienist in patient care;
3. The workshop content and process; and
4. The evaluation procedures used to determine if workshop participants did indeed make changes in their clinical practice.

Self-regulation in Alberta: The achievement of a goal

B. Walker, RDH; J. Juchli, RDH, BEd; and J. Pimlott, RDH, MSc, Alberta Dental Hygienists Association and University of Alberta, 9720-45 Avenue, Edmonton, Alberta, T6C 5E5.

Since their inception, dental hygiene associations world-wide have been committed to achieving professional recognition with the ensuing goal of self-regulation. Self-regulation has been achieved in several geographic areas — the Province of Alberta being one. The purpose of this paper is to present the Alberta Dental Hygienists Association's perspectives on the achievement of this goal.

The Alberta Dental Hygienists Association was registered under the Government of Alberta's *Societies Act* in 1965. The



Association made its first formal request for recognition as a profession in the late 1960's. During the 1970's and early 1980's the Government presented drafts of legislation which would have placed the regulatory controls with either dentists or physicians, not dental hygienists. Since acceptance of these proposed bills could not be attained, the Government called a moratorium on all dental legislation.

Recent policies by the Government of Alberta recognising self-regulation as an effective means of promoting public protection, resulted in renewed discussions of dental hygiene legislation. Self-regulation for dental hygiene was proclaimed November 1, 1990.

Self-regulation is a "balancing act". Numerous considerations must be addressed, for example: the Association's dual responsibility to its membership and to the public; the definition of scope of practice; the determination of practice standards; and the implementation of practice review and disciplinary procedures. These and other issues will be continually addressed through the Regulations and Bylaws.

This paper will present a discussion of events to date as well as an in depth discussion of the implications and projections resulting from self-regulation.

Dental hygiene curriculum — A review process for a course in restorative techniques

J. Clovis, DipDH, BEd, MSc, School of Dental Hygiene, Dalhousie University, 5981 University Avenue, Halifax, Nova Scotia, B3H 3J5.

Curriculum revision is a challenging process which requires consideration of past,

present, and future variables. The restorative curriculum in the School of Dental Hygiene at Dalhousie University was reviewed in light of the decrease in caries prevalence and the perceived diminishing demand for placement of restorations by dental hygienists. A multi-stage process was initiated by the establishment of a committee who agreed to investigate the history of the restorative curriculum in the School; the course offerings in other Canadian dental hygiene programs; and, the need, demand and utilization of restorative techniques by dental hygiene graduates. A significant change in the restorative curriculum was the shift from dentist to dental hygienist co-ordinators and instructors. Comparison of the Dalhousie curriculum with other Canadian programs was complicated by the variety of undergraduate and graduate offerings and provincial regulations. Senior dental hygiene students were surveyed regarding their prospective employer's expectations for placement of restorations. The restorative practices of graduate dental hygienists in Atlantic Canada were also assessed. Interpretation of these data and consequent revision of curriculum must be considered in light of existing educational beliefs and pragmatic constraints within the School of Dental Hygiene and the Faculty of Dentistry at Dalhousie University.

Preventive dental management and the pediatric oncology patient

Dale Scanlan, RDH, Children's Hospital of Eastern Ontario, Ottawa, Ontario.

Cancer may be described as the rapid growth of abnormal cells that invade adjacent normal tissue or spread to distant tissues (metastases) or both. Management of cancer usually involves treatment with drugs (chemotherapy), radiation (radiotherapy) or both. The chemotherapeutic drugs act by decreasing the rate that the cancer cells multiply and grow. The side effects of these drugs on the pediatric oncology patient include multiple oral changes during and after the treatment.

Visible changes may include:

- (i) Mucositis
- (ii) Bleeding gums
- (iii) Dry lips and mouth
- (iv) Fungal infections
- (v) Increased oral acid production due to decreased saliva flow

- (vi) Oral ulcerations
- (vii) Photo-sensitivity
- (viii) Tooth decay
- (ix) Arrested root growth and enamel formation
- (xi) Diet and taste alterations

The presenter will attempt to pictorially acquaint the viewer with some of the oral manifestations and familiarize them with preventive dental management.

Intentional and unintentional learning in extramural experience

J. Clovis, DipDH, BEd, MSc; M.G.E. Forgay, DipDH, BA, BEd, MA; J.G. Messer, BDS, FDS, DDS; and H.J. Murphy, EdD, School of Dental Hygiene, Dalhousie University, 5981 University Avenue, Halifax, Nova Scotia, B3H 3J5.

Extramural programs can provide a range of student experiences with resulting intentional and unintentional learning. An extramural program in northern Newfoundland is intended to provide senior dental hygiene students from Dalhousie University with experience in delivering care in a remote community and to enhance the dental care provided for the population served by Grenfell Regional Health Services. The program has evolved in three years to a two-week rotation of ten students selected on the basis of interest and academic achievement. To date the program has been assessed through the review of oral and written reports of students and supervisors. Although the primary objective is to influence the attitudes of students concerning working in a remote area, numerous indirect benefits are apparent. Students and faculty report a demonstrable increase in clinical skill and speed. Students also report an increase in their confidence, and appreciation for their exposure to a wide range of oral health needs in the client group. The less obvious and unintentional gains in social interaction are also reported. On one measure of attitude, the Culture Shock Inventory, differences favoured the students who participated in the Grenfell rotation, although statistical analysis did not show these to be significant. Students themselves suggest that the experience is an intermediate step to graduate dental hygiene practice as well as an introduction to a remote northern community, other health professionals and health care systems, and both resident and non-resident cultures in the remote community.

Children fluoride ingestion from dentifrice

H. Naccache; D. Lachapelle; L. Trahan; and J.-M. Brodeur, Ecole de médecine dentaire, Université Laval, Québec, G1K 7P4.

Previous studies have suggested that young children may ingest significant amounts of fluoride toothpaste and possibly be in danger of developing enamel fluorosis. The purpose of this study was to determine the association between the quantity of fluoride ingested during toothbrushing and age, quantity of toothpaste used and mouth rinsing habits.

Four hundred and five, 2- to 7-year old children, brushed their teeth in front of a portable sink and, depending on his habits, the child rinsed or not his mouth. The tubes of dentifrice in gel (0.24 per cent NaF) were weighed before and after use in order to determine the quantity of toothpaste used. After brushing, all expectorated saliva, liquids, and gel were collected in a 1 litre plastic beaker. The fluoride content of the collected liquids was determined with a fluoride ion specific electrode. The quantity of fluoride ingested was derived by determining the difference between the quantity used and rejected.

The amount of fluoride ingested decreased with age (0.358 mg to 0.175 mg, $p \leq 0.001$). The overall correlation between the quantity of dentifrice used and the quantity of fluoride ingested was 0.77. The children who rinsed their mouth ingested 0.178 mg of fluoride versus 0.253 mg for those who did not ($p \leq 0.001$). Therefore these results indicated that the quantity of dentifrice used as well as the age and rinsing habits of the children affected the amount of fluoride ingested during toothbrushing.

Clinical empathy

Renee Poss, RDH, BA, 145 Dunvegan Road, Toronto, Ontario, M5P 2N8

Empathy is defined as "the power of entering into the experience of or understanding objects or emotions outside ourselves". Oxford English Dictionary (OED) and "the capacity for participating in the feelings or ideas of another" (New Merriam-Webster Dictionary). Two terms occasionally confused with empathy are sympathy and insight. Sympathy is defined as "the capacity of entering into or sharing the feelings of another", specifically "being thus affected by the suffering or sorrow of another; a feeling of

compassion or commiseration" (OED). Insight denotes "sight or seeing into a thing or object" (OED). Although the terms clearly overlay, from these definitions ...[we] infer that empathy occupies an uncertain middle ground in relation to the [patient] object, not so far removed as is implied by the term insight, yet not as involved as implied by the term "sympathy"*.

In this paper, I will discuss the following:

1. How the evolution of a dental hygienist from auxiliary to colleague results in one's personal empowerment to be able to enter into the experience and maintain the distance necessary to clinically empathize with patients.
2. How the distances described in the definitions above are manifested in case reports of dental patients.
3. How clinical empathy results in success in a dental hygienist's relation to the patient.
4. How the collegial attitude shared by the dental hygienist and the patient is necessary to empower the patient to assume the responsibility for his/her own oral health.

* Berger, David M. (1987). "Clinical Empathy", Northvale, New Jersey, Jason Aronsen Inc., p.5.

Chairside evaluation of periodontal pathogens by use of a rapid enzyme immunoassay

M.J. Goulding, RDH, BS; L.A. Christersson, DDS; B. Snyder PhD; A.G. Zack, M.A; additional authors. Kodak Research Laboratories and Department of Oral Biology, State University of New York at Buffalo.

Periodontal diagnosis has experienced revived interest in recent years due to the emergence of new technologies. Computerized automated probes, computer-assisted radiographic analysis, and devices for chairside diagnosis are some areas of development.

However, clinical parameters alone do not allow for a clear evaluation of the periodontal status therefore adjunctive measures have been sought.

Scientific findings indicate certain gram negative bacteria as being site specific in pockets affected by periodontal disease have

provided ample basis for the introduction of microbiology to clinical periodontics. Increased emphasis in research has been placed on methods of achieving rapid and objective diagnosis, based on the presence of marker organisms.

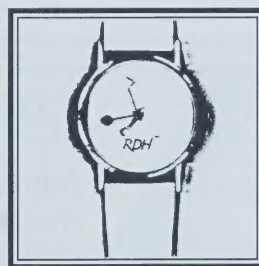
The recent development of new technologies now makes "microdiagnosis" possible, in the form of a membrane-based sandwich immunoassay to detect antigens of suspected subgingival periodontal pathogens. The technology is currently available in a configuration designed for the detection of three species that have been implicated as markers for periodontal disease: Porphyromonas (Bacteroides) gingivalis (Pg), Prevotella (Bacteroides) intermedia (Pi), and Actinobacillus actinomycetemcomitans (Aa). This assay uses a flow-through disposable device and polyclonal antibodies to detect species-specific antigens on the surface of a filter contained within discrete wells. Two paper points can be assayed in each disposable unit, in less than five minutes. The result yields a semi-quantitative visual interpretation along with associated positive and negative controls, displayed in an alphanumeric pattern. All strains tested to date have shown equal reactivity with no cross-reactivity of non-specific species. Detection limits for all three species are approximately 105 cells.

From a previous study performed on 29 adult patients with a recent history of periodontitis, site analysis showed a low antigen prevalence (5 per cent) in healthy sites and a high antigen prevalence (70-90 per cent) in diseased sites. The proportion of Pi and Pg positives, as well as the proportion of high antigen scores, increased with increasing pocket depths. Pi, Pg and Aa positive sites were found in 96.6 per cent, 58.6 per cent and 20.7 per cent of the patients respectively. All (100 per cent) of the patients had at least one of the three antigens in the diseased sampled sites. In addition, sampling of 1-4 of the deepest bleeding pockets gave an accurate representation of the whole mouth antigen profile.

This rapid alternative to laboratory-based analysis can therefore be used to accurately assess the relationships of these organisms to specific stages of human periodontal disease. It permits a large number of patients to be screened for the presence of Aa, Pi, and/or Pg, with no instrumentation of operator expertise. This test offers the dental hygienist, at chairside, the opportunity to precisely and quickly monitor those sites deemed at risk, thereby providing timely intervention to the ongoing destruction of periodontal disease.

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Highway 21
SHERWOOD PARK, Alberta T8A 4S6

- Proceeds will be used to fund projects of the Northern Alberta Dental Hygienists' Society.

February 1993

		LOCATION	FOR INFO CALL
5	A to Z System for Practise Mgmt.	U. Washington	(206) 543-5448
10	Update on Implants	U. Manitoba	(204) 788-6331
13	Hot Topics in Restorative Dentistry	Dalhousie U.	(902) 494-1674
19	Medications and the Elderly	SIAST — Wascana Campus	(306) 787-1375
26	Challenge of Implant Soft Tissue Maintenance	U. Washington	(206) 543-5448
26-27	Infection Control	U. Manitoba	(204) 788-6331
27-Mar. 1	Vernon Ski seminar	U. British Columbia	(604) 822-2626

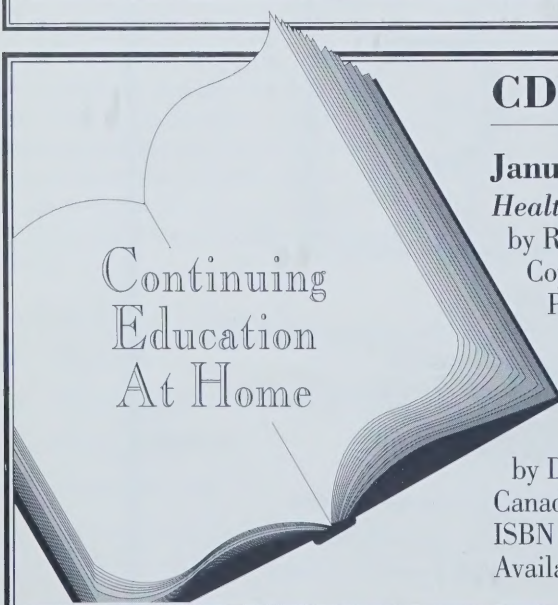
March 1993

3	Caries Treatment & Perio in the Future	U. Washington	(206) 543-5448
3	CPR Re-certification	U. Manitoba	(204) 788-6331
6	Dilemmas & Coping Strategies for Working Women	U. Saskatchewan	(306) 244-5072
19	Is there anything new in Implants?	U. Washington	(206) 543-5448
27	You Can Make a Difference — A Workshop in Communications	Dalhousie U.	(902) 494-1674
28	Dealing with the Aggressive Client	SIAST — Wascana Campus	(306) 787-1375

April 1993

2	Medical Emergencies — Beyond Basics	U. Washington	(206) 543-5448
3	Update on Radiographic Techniques	U. Manitoba	(204) 788-6331
14	Applied Pharmacology	U. Saskatchewan	(306) 244-5072
16-17	Perio for the '90s and Beyond	U. Washington	(206) 543-5448
24	Infection Control	Dalhousie U.	(902) 494-1674

Ongoing — "Multidisciplinary Gerontology" through the Continuous Learning Centre (CLC), Confederation College, Ontario. The CLC offers you the choice to learn at home or at the Centre, coupled with the flexibility of working at your own pace within an overall time limit. For further details call (807) 475-6416.



CDHA's Book of the Month Suggestion

January:

Health Care in Canada

by Ralph W. Sutherland and M. Jane Fulton

Copyright 1988. The Health Group. Distributed by The Canadian Public Health Association.

ISBN 0-9693537-0-7

February:

Women Under Stress

by Donald Roy Morse and M. Lawrence Furst

Canadian Hospital Association. Copyright 1987.

ISBN 0-919100-60-0

Available from your local library.

Book Reviews

Emergency Guide for Dental Auxiliaries
Janet Bridger Chergena. Delmar Publishers Inc., 2 Computer Drive West, Box 15-015, Albany, New York, 12212. Copyright 1987. Illustrations, indexed, 180 pages, \$29.95 (Can).

Reviewed by Sharon M. Compton, DipDH, BS, MA (Education), Assistant Professor, Division of Dental Hygiene, Faculty of Dentistry, University of Alberta, Edmonton, Alberta.

This book consists of 14 chapters and is directed towards undergraduate dental hygiene and dental assisting students. The book is also valuable review/refresher text for practising dental hygienists and assistants.

The book is clearly written and well organized. Each chapter begins with outlined objectives and key terms. Each topic area within the chapter is titled and highlighted with bold print for quick reference. Where applicable, the material within the chapter is organized in summary tables. At the completion of each chapter, there are references and review questions. The formatting of review questions includes multiple choice, true/false and problem-solving situations.

The following areas are included in the text: prevention and preparation of medical emergencies, and explanation and management of medical conditions. The book concludes with a brief chapter on legal issues of emergency care.

I highly recommend this text for use in undergraduate dental hygiene and assisting programs and for practising dental hygienists and assistants who desire a review of protocol for prevention, preparation and management of medical emergencies.

Advances in Periodontics

Thomas G. Wilson, Kenneth S. Norman, Michael G. Newman (Editors). Quintessence Publishing Co. Inc., 551 North Kimberly Drive, Carol Stream, Illinois, 60188-1881. Copyright 1992, 623 illustrations (400 colour), indexed, 400 pages, \$120.00.

Reviewed by Margaret Wilson, RDH, BEd, Clinical Assistant Professor, Dental Hygiene and Dentistry, University of Alberta, Edmonton, Alberta.

The purpose of this exciting new book is to discuss traditional approaches to periodontal therapy as well as new methods of treating inflammatory lesions. The book is designed to facilitate the flow of information from the researcher to the practitioner. To this end, thirty different clinicians and researchers have contributed to the text to make it an excellent source of current information.

The book is divided into four main sections. Section One provides thorough coverage of examination techniques currently used, with a window to the future. Disease activity and

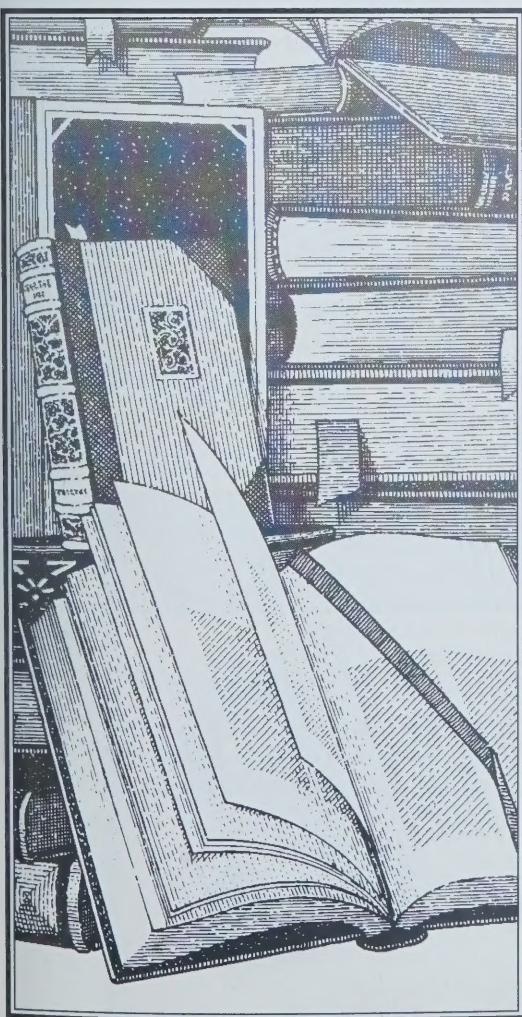
treatment planning are also discussed. Section Two explores methods of treatment for inflammatory periodontal diseases. In organizing these two sections the editors promote the concept that the great majority of periodontal lesions can be divided into two broad categories: chronic problems and more aggressive lesions. This particular organization allows for easy assimilation of the information presented.

Section Three discusses adjunctive care for periodontal patients with particular attention to enhancing esthetics and dealing with the medically compromised patient.

The Fourth section in this book focuses on Implant Dentistry, and includes information on pre-surgical treatment planning, radiographic techniques, choice of an implant system and clinical management and maintenance.

Super imposed on all this "state-of-the-art" information is a design which facilitates learning and referencing. Most chapters start with a review of current concepts before exploring clinical applications. Each chapter ends with a quick review of the material covered before an extensive listing of appropriate references. Of particular value are the excellent photographs and diagrams which accompany the text. The quality of these photographs is such that clinical techniques come alive. To have a histological diagram in close proximity to a colour clinical photograph and the corresponding radiograph brings research into the operatory.

By comparison to other texts, this book provides a most complete compilation of material on periodontal therapy making it a superb, if somewhat costly, text for the dental hygiene student. The book is also worthy of personal purchase as it is an excellent resource for the practising dental hygienist. It should be part of every Dental Hygiene School library. The editors are to be commended for "bridging the gap" between theory and practice.



Self-Assessment Test

Dental Histology

1. The initial budding off of tissue from the oral epithelium is called the:
 - a) bud stage
 - b) cap stage
 - c) bell stage
 - d) enamel organ
2. When the deepest part of the bud becomes concave, the next stage is known as the:
 - a) bud stage
 - b) cap stage
 - c) bell stage
 - d) dental lamina
3. Which cell group is NOT seen in the cap stage:
 - a) outer enamel epithelium
 - b) inner enamel epithelium
 - c) stratum intermedium
 - d) stellate reticulum
4. Which development stage occurs last:
 - a) bell stage
 - b) cap stage
 - c) bud stage
 - d) dental sac
5. Which cell layer is responsible for enamel formation:
 - a) inner enamel epithelium
 - b) outer enamel epithelium
 - c) stellate reticulum
 - d) stratum intermedium
6. The dental papillae forms:
 - a) dentin and pulp
 - b) dentin and periodontal ligament
 - c) pulp and periodontal ligament
 - d) dentin and cementum
7. What is the most highly calcified tissue in the human body:
 - a) bone
 - b) dentin
 - c) enamel
 - d) cementum
8. Cementum arises from the:
 - a) enamel organ
 - b) dental lamina
 - c) dental papillae
 - d) dental sac
9. Tooth development in the human embryo begins during the:
 - a) fourth week
 - b) sixth week
 - c) tenth week
 - d) twelfth week
10. Enamel producing cells are called:
 - a) odontoblasts
 - b) cementoblasts
 - c) fibroblasts
 - d) ameloblasts

Answers:

1.a) 2.b) 3.c) 4.a) 5.a)
6.d) 7.c) 8.d) 9.b) 10.d)

This self-assessment test was prepared by
Connie Sharuga, RDH, PhD, Division of
Dental Studies, College of New Caledonia,
Prince George, BC.



CDA Convention

CDA CONVENTION

Toronto 1993 April 28 - May 1

THE THEME FOR THE MEETING IS **ACTIVE LEARNING • ACTIVE LIVING**



THE 1993 CDA ANNUAL CONVENTION, HOSTED BY ONTARIO DENTAL HEALTH PROFESSIONALS PROMISES TO BE AN EXCITING EVENT. IT IS EXPECTED TO ATTRACT RECORD NUMBERS OF BOTH DENTAL PROFESSIONALS AND DENTAL INDUSTRY REPRESENTATIVES. THE EXPERIENCE AND EXPERTISE OF ONTARIO'S MEETING PLANNING STAFF WILL BE COMBINED WITH THAT OF THE CDA TO BRING YOU POTENTIALLY THE LARGEST DENTAL CONVENTION IN CANADA!

REGISTER EARLY AND PLAN TO MAKE HISTORY WITH US IN TORONTO NEXT SPRING.

What a pleasure it is for me as the Canadian Dental Hygienists Association President to invite the dental hygienists from across Canada to my home province. The Ontario Dental Hygienist's Association will be the hosts for the Canadian dental hygienists at the CDA/CDHA/CDAA annual convention in Toronto, April 28-May 1, 1993.

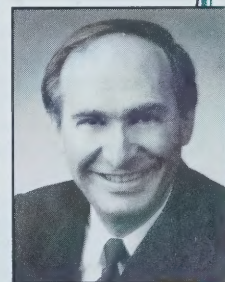


Our enthusiastic hosts have planned an excellent continuing education program and great social activities. You will have an opportunity to spend time with your friends as you enjoy the CN Tower and the Metro Convention Centre. The SkyDome, home of the Toronto Blue Jays is next door.

Dental assistants, dental hygienists and dentists will all be at the Convention Centre. Come with your colleagues and participate. **Active Learning • Active Living** is the theme of this year's convention. Let's do it!

Lorraine Boomhour, RDH
President, CDHA

It gives me great pleasure to have this opportunity to address the dental hygienists of Canada; dentistry is a team effort. In order to best serve the needs of our patients, we require the support of all of us who deliver oral health care and we can all be proud of the contribution of the Canadian Dental Hygienists Association to that effort. I am proud of the relationship that has been fostered between CDA and CDHA over the years, and our meeting this spring provides another opportunity for dentists and dental hygienists to pursue our professional obligation to continue learning.



The convention is taking shape as you read this article. The format differs somewhat from past years, and promises a wide range of continuing education programs, an exhibit hall filled with the latest dental industry representatives have to offer, and an exciting and entertaining social program.

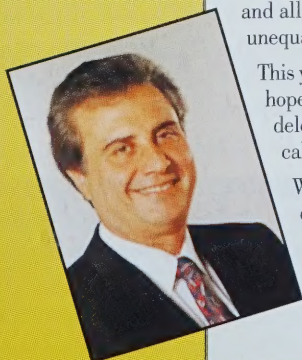
1993 promises to be an exciting year for dentistry and for our two organizations as we face new challenges. Continued success will depend on our ability to work together in support of the collective interests of organized dentistry. Let's continue to make the Canadian Dental Hygienists Association and the Canadian Dental Association partners in progress.

Bernard Dolansky, DDS
President, CDA

On behalf of the Canadian Dental Association, I am inviting you to attend the 1993 CDA Annual Meeting being held in Toronto this spring. Lorraine Boomhour, the committee member representing the Canadian Dental Hygienists Association, and all the other committee members are working hard to prepare a program unequalled in value especially for you.

This year we are incorporating a theme to give the meeting some character. We hope our slogan **Active Learning • Active Living** will serve as a reminder to delegates to use this event as an opportunity to get in shape mentally, physically and emotionally. Casual and relaxing attire is encouraged.

We look forward to welcoming you to what could very well be the largest dental professionals meeting in Canadian history! If you require a registration form or more information, please refer to the CDA Journal and/or contact CDA Conventions at 1-800-267-6354.



Michel Jahjah,
DDS, General Chairman, CDA Conventions

THE THEME OF CONVENTION '93 IS ACTIVE LEARNING • ACTIVE LIVING AND THE FOLLOWING CLINICIANS HAVE BEEN SCHEDULED FOR YOUR EDUCATION AND ENJOYMENT:

- **Implant Maintenance**
Salme Lavigne, RDH, BA, MS
- **Developing a Dental Hygiene Department**
Annette Linder, RDH, BS
- **Fluorides**
Christopher Clarke, DDS, MPH
- **Geriatric Dentistry**
Ron Ettinger, MDS, DDS
- **Periodontics**
Richard Wilson, DDS

- **Nutrition**
Barbara Casselman, BAA, FncFS
- **Chemical Dependency**
Chris Christianson, ML
- **Paedodontics**
Marvin Berman, DDS
- **Infection Control**
Milton Schaefer
- **Practice Management**
Anita Jupp

This is just a sampling of the scientific program!



Photo courtesy of MTCVA.

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Class of 5T8

Class of 6T3

Class of 6T8

Class of 7T3

Where are you now?

Great opportunity for cross-Canada participation at your Class Reunion during Convention '93, April 28 - May 1, in Toronto.

Meet and Greet

A gathering of your dental hygiene colleagues in the OASIS area on the Exhibit Floor of the Convention Centre. A chance to win door prizes, see "old" friends, and reunite at the end of the day. Then on to the **OPENING CEREMONIES, Thursday April 29, from 4-5 pm**, featuring the Famous People Players. Look for information at dental hygiene registration.

The Convention will be housed in the Metro Toronto Convention Centre in downtown Toronto, and will offer participants a wide range of continuing education programs as well as an exhibit hall filled with dental industry representatives eager to show you the very latest in technology and treatment.

CITY LIGHTS

Toronto is internationally recognized as a "great city". So much to offer and very limited space to print it all. Here is a selection of what awaits you before and after Convention '93, April 28 - May 1. And all of these attractions are just minutes away from Convention headquarters!

SHOPPING

- ★ Eaton Centre — 1,000 shops and restaurants all under one roof!
- ★ Yorkville & Bloor Street — boutiques, select gift shops, and great cafe dining
- ★ Queen Street — unique, trendy and full of bistros

RESTAURANTS

Too varied both in culture and cost to list. Toronto will offer you cuisine from Australia to the Yucatan and everything in between!

SPORTS

- ★ SkyDome — home of the 1992 World Series Champions! Toronto Blue Jays! The 1993 season begins early in April, game schedules will be available in January.



Phone (416) 341-1111 for ticket information.

THEATRE

- ★ Elgin Theatre — **Joseph and His Amazing Technicolour Dreamcoat** by Andrew Lloyd Webber
Tickets: 1-416-872-5555
- ★ O'Keefe Centre — Ballet: **Romeo and Juliet**
Tickets: 1-416-872-2262
- ★ Pantages Theatre — **The Phantom of the Opera** by Andrew Lloyd Webber
Tickets: 1-416-872-2222
- ★ Royal Alex Theatre — **The Good Times are Killing Me**, a comedy by Linda Barry
Tickets: 1-416-872-3333

Top of the Tower

A cocktail reception for all dental hygiene registrants honouring CDHA President, Lorraine Boomhour, and ODHA President, Kathleen Feres Patry, on Friday April 30 between 5-7 pm. Your CDHA/ODHA invitation entitles you to a free ride up the CN Tower for the most panoramic view of Toronto! Come and celebrate with us at the "Top of Toronto".

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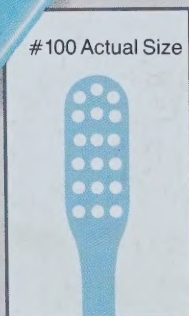
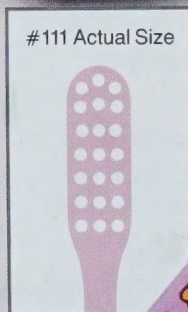
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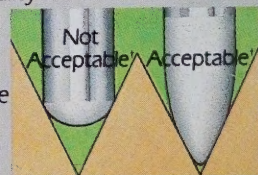
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THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
JOURNAL DE L'ASSOCIATION CANADIENNE
DES HYGIENISTES DENTAIRE

PROBE

VOL 27, NO 2

MAR/APR 1993 MAR/AVR



SHERYL FELLER, RDH
Sanford, Manitoba

Colleagues From  Coast to Coast

Research • Practice • Education • Health Promotion

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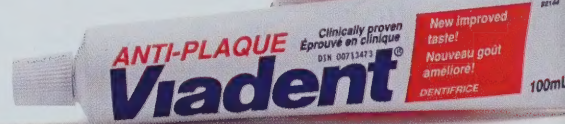
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1. Hanna JJ, Johnson JD, Kufnec MM. Clinical evaluation of sanguinaria-containing toothpaste and oral rinse. American Journal of Orthodontics and Dentofacial Orthopedics, 1989, Vol. 3: 199-207
2. Harper DS, Mueller LJ, Fine JB, Gordon J, Laster LL. Clinical efficacy of a dentifrice and oral rinse containing sanguinaria extract and zinc chloride during six months of use. J Periodontol, 1990; 61: 352-358



Targeting

We are now far enough into 1993 that we may begin to feel guilty for those resolutions we have failed to keep! Though I must weep for those five pounds I intended to shed, I can celebrate my actions toward healthy living for the new year.

I currently have, in my appointment book, dates and times scheduled for a visit with my dental hygienist and my gynecologist. I must admit, it did take fortitude but I persisted and I was finally able to pick up the telephone and make those calls. Why these appointments are so hard to make I cannot say, but they are important.

A thorough head and neck examination, a periodontal maintenance and monitoring appointment, a breast examination and a pap smear are categorized as screening procedures targeted to specific high risk diseases to which women in my age category (somewhere between 19 and 65) are susceptible. They are all fairly innocuous procedures and need attending to on a regular basis.

The idea of "targeting" to screen for specific conditions arose several years ago when the American Association of Gynecologists advocated the yearly pap smear to detect early signs of cervical cancer. This successful campaign has been responsible for lowering the incidence of cervical cancer by a statistically significant percentage. The majority of women in North America now consider it a "must do" on their yearly calendars. This is one screening procedure that is proven to be cost- and health-effective.

"Why these appointments are so hard to make I cannot say, but they are important."

In times past the yearly "physical" examination was common, seemingly more for men than for women. Women were thought to present themselves at the doctor's office, often



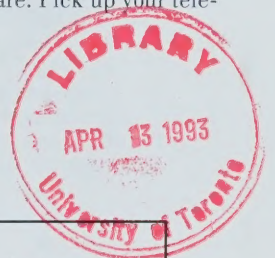
MARILYN GOULDING, RDH, BSc

enough, throughout their childbearing years, to forgo any additional yearly examination. The fact is, that although these people did clear their consciences they rarely cleared any health problems. Statistics show these cross-sectional windows into the whole being included costly tests and examinations unnecessary unless specific markers (symptoms) for disease were present. What did arise was insight into which of these screenings were valuable. Something as simple as taking vital signs proved to markedly increase the early detection of high blood pressure, a warning sign of heart disease.

Given today's fiscal health care restraints and society's time constraints, a more targeted approach to the health check list seems appropriate. Our researchers have been busy identifying which risk determinants (those attributes you can't change such as age and gender) connect to which diseases, which risk factors (those attributes that can be modified such as smoking) predispose us to disease, and finally risk markers for disease (not necessarily causal factors but rather indicators of disease such as bleeding in gingivitis).

All this information may be used to save us time and money in the quest for health and longevity. In our practices we can be screening for oral cancer (a less frequently occurring but particularly devastating form of the disease), hypertension and oral bacteria responsible for caries or periodontal diseases. In our physicians' offices we can be screened for cholesterol levels, breast cancer, cervical cancer and prostate cancer.

Targeted screening is a financially responsible and time efficient way to monitor ourselves and our clients for debilitating and sometimes fatal diseases. Let's practise what we preach; health care. Pick up your telephone today!





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To keep in touch with, correspond, write, report, tell, disclose. These are all words describing aspects of communication. What do we mean by "Communication?" We can define it quite simply as the imparting or exchanging of thoughts, ideas, feelings and information. As a dental hygienist the ability to effectively communicate is of the utmost importance. Professionally, we communicate with clients and other health care professionals and we should be consciously trying to improve our communication skills. We must ensure that we are understood and that we actively listen to others to better understand them.

I believe that within our profession, there has been an improvement in our communication. As an organization the CDHA members, board, advisors and resource people and executive have tried to make their views known but also have sought out the views of others. We intend to continue that tradition by increasing dialogue through the Journal and newsletter.

***Because communication is
a two way street we need
to hear from you.***

***Your contributions
are essential.***

As you have seen, *Probe*, the CDHA National Journal has undergone changes in the last issues. People across this country are responding very positively. Because communication is a two way street we need to hear from you. The editorial staff encourages all comments, and letters to the editor are always welcome.



LORRAINE BOOMHOUR, RDH

CDHA Practice and Regulation Council are reviewing the recommendations and guidelines from the workshop, "Evaluation of Current Recommendations Concerning Fluorides." The council is looking at the guidelines and how they relate to dental hygiene practice in public health and clinical practice. If these guidelines have affected you in any significant way or if you have any suggestions to help the council, please contact the CDHA Central Office. Your contributions are essential.

Dialogue has increased in dental offices between dental hygienists and their employers. Dentistry is concerned with the intent of CDHA's, "The Management of Dental Hygiene Care" position statement. This has given dental hygienists an opportunity to explain to dentists how important interaction and co-operation is between dentists and dental hygienists. We need to discuss patient care and make sure that all options are looked at. The Canadian Dental Hygienists' Association supports collaborative practice, and we must ensure protection of the public and high quality care.

There are four kinds of people in the world:

- Those who make things happen.
- Those who watch things happen.
- Those who wonder what happened.
- Those who don't know that anything happened.

Play a role in what is happening. This is your association and every opinion and suggestion counts. We have seized some great opportunities in the last year to communicate within our profession, with other health care professionals and with the public. Continue the discussion. Let's rebuild our compassion, our understanding, our openness, and our opportunities to be understood. Let's take time to listen and let's work hard to understand each other. 

Lorraine Boomhour, of Brampton, Ontario, received her Dental Hygiene Diploma in 1978, and obtained her Expanded duties in Dental Hygiene in 1979. She has been active in both CDHA and ODHA for many years, serving as director and president (1987-88) respectively. She is currently in private practice.

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Universal Precautions

In response to a recent editorial by John Hardie, [*Probe*, Vol. 26, no. 3] I must also state that I cannot agree that "most of our dental patients are healthy". I am further compelled to state emphatically that the dental hygiene treatments of scaling and root planing are definitely *invasive*. As a clearly invasive procedure, that is one which introduces bacteria (and potentially other pathogens) into the blood stream, it is incumbent on all health professionals to protect the public from cross-contamination. The use of **Universal Precautions**, that is the sterilization or disposal of any object that is used in the oral cavity, the surface disinfection or barrier of any object that is touched during procedure and the use of gloves, masks, gowns and eye protection by health professionals, is an effective mode to protect the dental patient and provide a secure environment for patient and professional alike.

Although Dr. Hardie does state in his editorial that hepatitis B (HBV) is the pathogen for which most of the infection control guidelines have been designed, this statement is not the thrust of his article. If I may borrow his own words, seemingly heretical statements as "HIV may not be the cause of AIDS" demand further explanation. While an editorial may not be the format for presenting scientific research, neither is it the format for perpetuating and propagating anxiety. HIV is in fact a very fragile virus which can be killed in seconds with temperature change or with simple hand soap. HBV is far more virulent, able to live viably on counter tops, charts and radiographs for longer than 48 hours, able to remain active under a fingernail despite repeated washing, and is not inactivated by the majority of disinfectant solutions on the market. Vaccination of clinical staff most certainly protects them from possible HBV transmission, but what will protect the dental patient from inadvertent transmission? Treating every patient as though he or she were infected and using **Universal Precautions** in the dental office is the only way to prevent cross-infections from occurring.

As a dental hygienist in the Oral Medicine Department of the Calgary Foothills

Hospital, I estimate that I see on a daily basis at least one HIV-infected patient and one HBV-infected patient. Sometimes the patients present with concomitant HIV, HBV, HPV, EBV, TB, herpes and candidiasis infections. Bear in mind that these patients did not arrive at the Foothills in full disclosure, on the day of their infection. They spent many months or years in a private practice, unable to disclose their medical history because, quite simply, they did not know they were infected. Some patients will not disclose their medical history because they are in denial, others perhaps because they fear the reaction of having anyone know. I have total confidence in the protocols which provide security for our patients and staff. I can't help but wonder if Dr. Hardie would like to be a patient of our clinic, without the use of **Universal Precautions**.

Janet Erikson, SDT, RDH, BED
Oral Medicine Dental Clinic,
Foothills Hospital

Probe's new look

Just received the *Probe*. I think it looks great — your editorial was great — the whole publication is super. Things like this make me proud of our profession.

Darlene Thomas, RDH

I would like to take this opportunity to congratulate all those involved in the publication's renewed image.

I am proud and honoured to have my article published in this quality journal.

Marsha Stein, RDH
[whose scientific article *A Literature Review: Oral Irrigation Therapy. The Adjunctive Roles for Home and Professional Use* appeared in *Probe*, Vol. 27, no. 1]

Minister of National Health and Welfare
Ministre de la Santé nationale et du Bien-être social
CANADA

Mrs. Carole Worobey
Executive Director
Canadian Dental Hygienist Association
Suite 201
1010 Merivale Road
Ottawa, Ontario
K1Z 6A5

Dear Mrs. Worobey:

I am very pleased to inform you that on November 20, 1992, I will be releasing the new Food Guide entitled *Canada's Food Guide to Healthy Eating*.

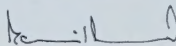
The development of *Canada's Food Guide to Healthy Eating* has been the result of consumer research and a broad consultation process which included representatives of various governments, health professionals and their associations, non-government organizations, industry and universities. I would like to take this opportunity to express my gratitude to you and your organization for your involvement, your valuable input and your support during this comprehensive process.

I will be pleased to send you a copy of *Canada's Food Guide to Healthy Eating* tear sheet, consumer booklet and fact sheets for communicators and educators, as soon as these materials become available.

The Food Guide has always been a popular and widely recognized resource promoting healthy eating in Canada. I look forward to future collaboration as we work together in promoting this new Food Guide for the benefit of all Canadians.

With every best wish.

Yours sincerely,


Benoît Bouchard

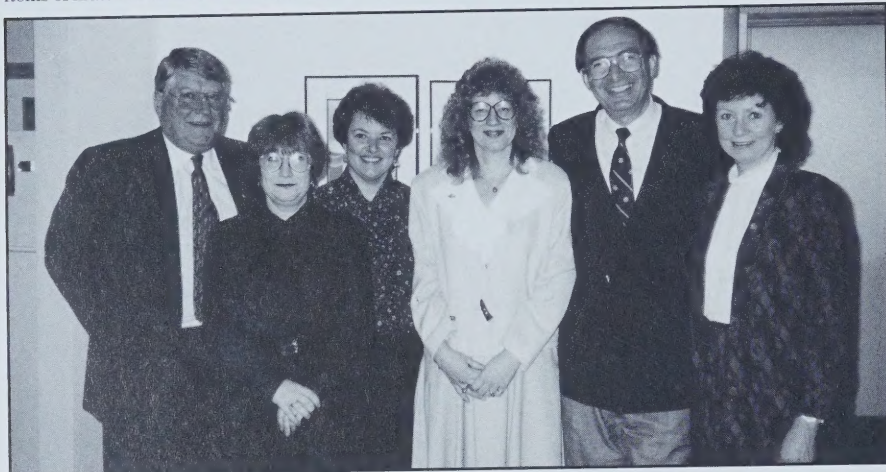
Ottawa, Canada K1A 0K9

We hope that you savoured the new *Canada's Food Guide* sent with the Jan/Feb issue of *Probe*. Copies of this material are available in French — «pour mieux se servir du guide alimentaire» and «Renseignements sur le Guide alimentaire à l'intention des éducateurs et des communicateurs» — from **CDHA, 1018 Merivale Road, Suite 201, Ottawa, Ont. K1Z 6A5**

CDHA/CDA Management Meeting

While in Ottawa for council sessions (January 1993), CDHA Executive had an opportunity to meet with Dr. B. Dolansky, CDA President, and Mr. J. Neilson, CDA Executive Director. Many items of mutual benefit and interest were reviewed

fostering new and continued opportunities for partnership. The meeting was very positive, and highlighted the importance of collaborative practice in a widening health delivery network.



Meeting in Ottawa were (from the left): J. Neilson, CDA; C. Matheson Worobey, CDHA; L. Elkins, CDHA; F. Cotton, CDHA; B. Dolansky, CDA; L. Boomhour, CDHA.

Federal-Provincial Dental Directors Health Council

The Federal-Provincial Dental Directors Health Council held its thirteenth annual meeting in Regina, Saskatchewan, October 28-29, 1992.

The Council consists of the dental directors, or senior dental advisors, of the federal, provincial and territorial governments. Two dental hygienists represented their respective provinces — certainly an historic occasion!

The Council constitutes a very useful forum for members to share program information, policy development and strategic planning techniques. It also provides the opportunity to exchange ideas, study common problems and compare experiences.

The Council will reconvene in Charlottetown in October, 1993.



Participants of the 13th annual Federal/Provincial Dental Health Council in Regina, from the left [back row]: Dr. Pam Glassby (Yukon); Dr. Robert Romeke (PEI); Dr. Michael Lewis (NWT); Dr. Gordon Thompson (Alta); Dr. Todd Hartsfield (Sask. - Northern Dental Services); Dr. Don McFarlane (Ont); Dr. Getty Joecs (NS); David Warren (Chairman, Sask); [front row] Rhonda Plett, RDH (Acting - Man.); Jill Rogers-Cando RDH (NB); Dr. Jack Andrus (Health & Welfare Canada); Lou Karpinski RDH (Dental Health Services - Sask).

CDHA Membership Draw

All membership applications received by October 31, 1992, were eligible for this draw.

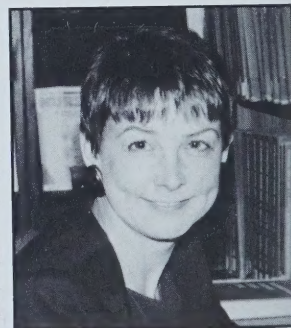
The lucky winner of free CDHA membership for 1992/93 is:

Johanne Smolarz, of Brantford, Ontario.

Primary Health Care Specialist

Brenda Shestowsky began working last September as the Canadian Nurses' Association's new nursing consultant for primary health care. Basically she has two major goals in keeping with the CNA's five-year primary health care plan. First, she is responsible for helping member associations to adopt and/or implement primary health care (PHC). Secondly, Shestowsky will work at making the CNA's position on primary health care known at a national level.

Shestowsky's research experience began in 1977 when she participated in the first nurse-developed organization to look at promoting health in a community setting. The McGill University Workshop: A health resource, was the first PHC model in Canada. Staffed and run by nurses, it was implemented as a research project for three years. Shestowsky was intrigued by the experience and decided to further her education in health promotion and education activities.



Shestowsky went on to get her master's degree in primary health care from the University of Connecticut. After graduating, she returned to Montreal where she accepted a fellowship with the Kellogg Institute for Advanced Studies in Primary Health Care.

Most recently she's been a self-employed health care reform consultant with clients including the Aboriginal Nurses Association of Canada, the Eastern Ontario Health Unit, and the CNA where she compiled an inventory of PHC activities across Canada.

Shestowsky says she's looking forward to being part of the health care reform challenge. She sees it as a long-term initiative requiring a new infrastructure and massive re-education of health professionals and the public.

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The Older Adult Packages:

- I "Oral Health in the Elderly: A Workshop Curriculum and Teacher's Guide".
- II "Oral Health Education for the Elderly... A New Preventive Dental Care Program".
- III "Training and Motivational Materials in Geriatric Dentistry".

Manuals

- IV "Geriatric Oral Health: A Training Manual For Long Term Care Facilities".
- V "Assessing the Aging Mouth".

Slide-Script Set

- VI "Senior Smiles".

Videotapes

- VII "12-Minute Videotape (VHS) For The Elderly".
- VIII "Options: Dental Health in Later Years".
- IX "The Senior Smile".
- X "Oral Health and the Elderly".

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Special Needs Slide-Script Set:



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Hygienists' Association, The Academy of Dentistry for The Handicapped and the Johnson & Johnson Professional Dental Care, a Division of Johnson & Johnson, whose goal is to provide education which will help improve the quality of oral health care for individuals with disabilities.

This package gives a wide variety of information on the oral health care of those with special needs. It can also be used to educate the care givers and family members involved. The package includes a quick reference guide to the 40 slides, extensive scripts (ideal for speakers making presentations on this topic), glossary of terms for the use of non-professionals, sources, and a bibliography. A really useful addition is the accompanying folder "Preventing dental diseases in children with disabilities", containing numerous education materials to be duplicated as needed. (two available)

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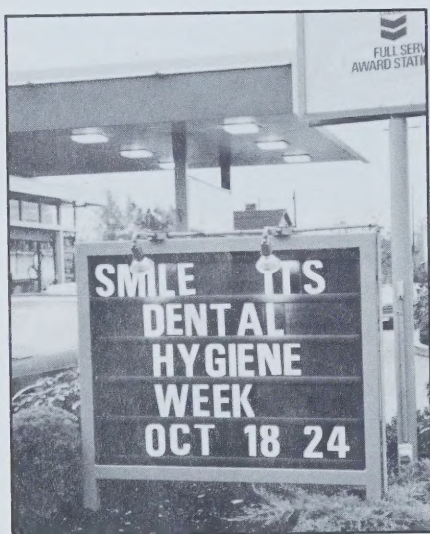
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National Dental Hygiene Campaign 1992

The ***Behind Every Great Smile*** NDHC was one of our most successful campaigns. The number of dental hygienists that participated was incredible. Our focus on Older Adults was a great choice, and coupled with CDHA's Professional Conference New News for Older Smiles, it really put dental hygienists' wheels of creativity to work.



Some of the new activities included:

- wellness fair with other health professionals for professionals
- "bridge" grab bags at a seniors centre
- dry-mounting the fact sheets and posters for a dental office's waiting room
- two local gas stations had NDHC signs and handed out free toothbrushes
- a mock arrest informing dentists of NDHC
- publishing articles in French
- raising money for the Cancer Society

The materials available for NDHC were:

- **Fact sheets** on Mouth Care, Gum Disease, Denture Care, and Oral Cancer Care. Older eyes found the large size print easy to read.

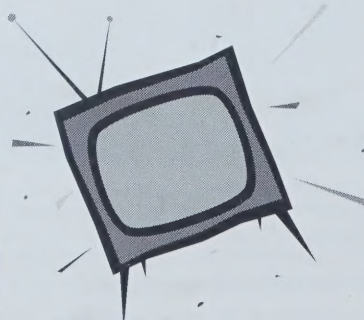
- ***Behind every great smile... is a dental hygienist*** sweatshirts were a huge success.

- **Display balloons** were sold out.

- **Book-marks** were a great way to remind seniors of dental hygiene.

The previous campaign fact sheets are still available on **dental hygienists, gum disease and oral care**, plus the little to **remember** pads. Sweatshirts remain in demand — and don't forget that all these items can be ordered year-round from CDHA.

The media coverage improves each year as the public becomes more familiar with NDHC. 145 press kits were distributed to the media, appropriate health care associations, seniors' organizations and groups. They contained press releases, posters, display balloons, bookmarks, samples of the Older Adult fact sheets, and copies of Facts about Dental Hygienists to provide background information. Also 112 information kits were sent to public health units across Canada. Plus many local media contacts were made by dental hygienists. A number of television and radio interviews were conducted in local areas. In addition, numerous newspaper interviews in dental offices were published in local papers. The array of photographs that accompanied NDHC evaluation forms was fantastic, and some of them are in this issue of *Probe!*



Thank you to all dental hygienists who volunteered for National Dental Hygiene Campaign.

- Gander, Nfld., put on a display in hospital cafeteria.
- Halifax, N.S., handed out pamphlets and gave away bridge grab-bags at a seniors' bridge game.
- Moncton, N.B., put on a mall display. As well, toothbrushes donated by dentists were distributed at the paediatric unit of a local hospital.
- Fredericton, N.B., promoted NDHC in the Real Estate Guide and local radio station aired an interview with a dental hygienist.
- Miramichi, N.B., distributed posters to seniors' residences. The local radio station and advertising channel ran the fact sheets.
- North Shore, N.B., had 100% participation by CDHA members. Promoted NDHC through local radio and television stations. Provided lunch to veterans at a hospital — dished out oral health information as well.
- Upper St. John River Valley, N.B., gave bilingual presentation at a seniors' home with individual screening and instruction.
- Canadian Forces Dental Services, Valcartier Base, Que., gave a presentation on dentures and oral cancer.
- Algoma, Ont., handcuffed local dentists in "mock arrests" who were unaware of NDHC — and the money raised was donated to the Cancer Society.
- Halton-Peel, Ont., encouraged dental hygienists to wear the ***Behind every great smile*** sweatshirts during the campaign. A seniors' residence was visited and complimentary denture cleanings performed. Displays were set up in local pharmacies and libraries.



- Hamilton & District, Ont., promoted NDHC with a banner in front of Hamilton City Hall.
- Huron-Grey-Bruce District, Ont., took grade one children on a tour of a newly renovated dental office.
- Kingston & District, Ont., held in-service session with RN's at a local hospital, focusing on the oral health care of their patients.
- London & District, Ont., set up displays at a local pharmacy and library. Oral care kits handed out at a food bank and women's community centre.
- Niagara & District, Ont., created an ingenious window display featuring a "mermaid" dental hygienist.
- Ottawa-Carleton, Ont., handed out fact sheets at a local mall.
- Sarnia & District, Ont., held a denture ID clinic.
- Sudbury, Ont., gave two interviews (one in English, and one in French) which were aired during the campaign.
- Thunder Bay, Ont., gave numerous presentations focusing on senior smiles.
- Toronto Central, Ont., supplied dentally correct snacks to a moms and tots group.
- Toronto North, Ont., visited senior's home and set up a mall display.
- York Region, Ont., distributed diet and nutrition pamphlets to teens and seniors.
- University of Manitoba set up table clinics on perio infection control
- Saskatoon, Sask., set up a display table at a "Welcome Wagon" and dental products were given as door prizes.
- Edmonton, Alta, organized a message on McDonalds calendar.
- Lloydminster, Alta/Sask., provided in-service at a local seniors' centre.
- Medicine Hat, Alta, set up table clinics for seniors.
- Stoney Plain, Alta., worked with physiotherapists to adapt toothbrushes for seniors.

- Camosun College, B.C. involved with the impact of dental hygiene on other allied professionals such as community support workers, continuing care assistants.
- Grandville Island, B.C., ran an information booth and distributed pamphlets and samples.
- Sunshine Coast, B.C., emphasized oral health care at a local seniors' group.
- Victoria & District, B.C., set up a mouthwash display.
- White Rock, B.C., spoke at a "wellness" fair.

For those of you unable to join in the fun of promoting dental hygiene, we will be looking forward to helping you plan an activity for Campaign '93—October 17-23. The focus is on children aged 6-10 years. Details and the launching of the new poster will be in the May/June issue of *Probe*. **CDHA is pleased to announce that Procter & Gamble and CDHA have joined together in a partnership to promote personal and professional dental care to school-age children in Canada. Start planning now!**

Dawn Mueller, National Dental Hygiene Campaign Co-ordinator.



Please print or type

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1018 Merivale Road, Suite 201,
Ottawa, Ontario K1Z 6A5

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Address: _____ Suite #: _____

City: _____ Province: _____ Postal Code: _____

Telephone: () _____ CDHA Membership Number: _____

_____ Cheque/Money order enclosed VISA Number: _____

Expiry Date: _____ Name of Cardholder: _____

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Back to the Future: *Appropriating our Traditions*

By:
Lynda M. Mickelson, RDH, HBA
(Occupational Ethics)

The clinical practice of dental hygiene has become technologized, specialized and fragmented. The acceptable approach to client care is the technical one. Find the calculus and remove it! Increased automation makes the delivery of procedures more fragmented. Frequently dental hygienists in private practice dental offices operate as clinical technicians focused on treatment in the small area of the sulcus.

In order to rediscover the true comprehensive nature of dental hygiene, it is necessary for dental hygiene to gather back its original purpose.

Traditions

What was the original purpose? What are our traditions? What is the true comprehensive nature of dental hygiene care? In the early 1900's a few dentists were discovering the merits of oral hygiene. One was Alfred C. Fones of Bridgeport, Connecticut, who developed an intense interest in prevention. He was convinced that through education and prophylactic procedures 80 per cent of all dental operations could be prevented. He thought dental practice could be refocused from treatment of disease to maintenance of health.¹ Once Fones excelled in the procedures, he trained Irene Newman, his cousin and assistant, to perform the procedures. I suggest that Fones and Newman established a professional partnership for the benefit of their clients. Fones cared about his patients and he entrusted Newman with the responsibility of dental hygiene treatment and education. The true comprehensive nature included the mechanical, technical and humane. The technical service was provided, the client was educated and motivated to participate in achieving oral wellness.

Dr. Fones recognized that an effective way to increase the general awareness of the importance of oral health, proper nutrition and the prevention of decay was to teach the children in the public schools. He developed a course of instruction in general health maintenance and specific oral hygiene techniques in the Bridgeport public school system. The later trend towards private dental practice suggests a major shift in the original focus of the dental hygienist's role.

As Darby states: "History suggests that the dental hygienists' primary concern has been for the whole person ... and for the role of the environment and person in fostering or preventing oral diseases."² The unifying principles of dental hygiene are prevention of oral disease and promotion of health. By legislation and education dental hygienists were given the responsibility to attain a clean healthy functional oral environment for the patients to maintain.



LYNDA M. MICKELSON, RDH, HBA

This idea of providing a better service by educating patients in prevention was carried out by means of symbiosis. Newman worked with Fones as co-therapist, and they had a collaborative relationship. Aldo Leopold states in *A Sand County Almanac*: "Politics and economics are advanced symbiosis in which original free-for-all competition has been replaced, in part, by co-operative mechanisms with an ethical content."³ Newman and Fones became interdependent individuals evolving modes of co-operation in order to carry out the principles of prevention of disease and promotion of health. What an unusual situation! These people had a blood kinship, sharing care and concern for each other — and the people for whom they provided service. Caring is not part of today's jargon. Empowering is a modern word for caring and, I believe, carries with it much more power, especially for women.

Empowering is about: giving people the ability to influence decisions, sharing of available information; involving appropriated people in needs assessment; accomplishing and completing challenging projects; the opportunity to work and meet with significant other people; conflict resolution and negotiation, orientation in new circumstances; flexibility to revise structures and schedules and surfacing affirming and working with differences.⁴

Caring is about: paying close attention or careful need to something; taking responsibility or tending to something; taking charge or protecting; feeling concern; having interest in something; and liking something.⁵

Although the words are different, there are many similarities in the nature of the activities signified by the words. Working with people is much more effective if appropriate responsibilities are assumed and genuine concern and interest is expressed among individuals.

Caring or empowerment is not an overt expression in many dental offices, is it? What happened? How did we become focused technicians?

Dental hygienists have allowed themselves to be controlled by their environment. That is they gave up ownership of their dental hygiene procedures and allowed dentists to assume direction. Dental hygienists have apathetically accepted dentists' emphasis on technical procedures. Often, compromising our principles has been easier than engaging in collaborative discussion with the employing dentist for the betterment of the client. Dental hygienists must rekindle the tradition

of assuming responsibility for the appropriate dental hygiene care of the client.

In the *Human Act of Caring: A Blueprint for the Health Professions*, Sister M. Simone Roach states that material affluence, an abundance of material things leads to a hollowness. "The possession of things destroys at least temporarily, the very condition for the possibility of caring."⁶ This trend to have an abundance of things has been analyzed by Rollo May, in *Man's Search for Himself*. The trend toward increased affluence and power involves fierce competition and highly refined technology, automation and computer use. These factors lead to an inability to communicate deeply personal feelings to each other. All these reflect the person's inability to care — to care for oneself or to reach out to others. All of these inhibit the full development of individuals and communities.⁷

Dentistry exemplifies these trends. The 50's were economically rewarding years for dentists. There were so many teeth to be filled and mouths to be "cleaned" that the use of dental hygienists increased in more offices and the number of procedures were expanded to include restoration functions.

Over the years society's demands for dental services often have become directly related to union benefits and company insurance plans. When people are laid off work or lose jobs, their benefits cease, so they don't seek dental treatment. In recessionary times, in order for dentists to maintain a constant income they may assume the dental hygiene procedures themselves.

How do we gain control over working conditions? How do we become empowered? How do we learn to care again? Perhaps we need to reflect on the fundamental human values in society. People in the world who value techniques and quick fixes are preoccupied with the question, "What can I do?" There is little time or place for, much less contemplation of, the question, "Who am I?"⁸

Self-Regulation: Accountability and Responsibility

Under provincial legislation more dental hygienists are becoming self-governing. This process of recognition of dental hygienists as responsible accountable professionals will empower dental hygienists. Dental hygienists will learn to take ownership for their scope of practice. I stated that empowering means giving people the ability to influence decisions, sharing information, assessing needs, completing challenging projects, working with significant other people, negotiating and resolving conflict and revising structures and schedules. Self-regulation will involve all of these things. As dental hygienists take ownership for their knowledge and skills, self appreciation will develop. Dental hygienists will learn to care about themselves.

Shirley Bassett is another dental hygienist who has recognized this process:

Dental hygienists are beginning to experience the empowerment process as they move forward to gain control of their own profession. The good news is that the very struggle they are engaging in, will in itself, facilitate empowerment.⁹

Through total quality improvement activities sponsored by the self-governing bodies in Canada, dental hygienists will gain self-esteem and self-respect. Equipped with these qualities, registrants will recognize their right to ask questions of themselves, and of others.

Self-regulation carries with it responsibilities and obligations:

Professional privilege is a function of the autonomy bestowed upon the 'expert' by society. The professions are granted autonomy in the sense that they are allowed to be self-regulating and self-disciplined. Professional (self-governing) associations set criteria for competence and are granted the right to the exclusive practice of the profession ... Professional privilege arises as a result of a 'special relationship' between professional and society which implies a set of correlative duties. The professional's fundamental duty is to ensure that his or her expertise is used primarily for the well-being of society.¹⁰

"The first consideration of the dental hygienist who suspects... unethical conduct by members of the dental profession should be the welfare of present clients and... potential harm to future clients."

Dental hygienists will be expected to be autonomous in his or her daily practice. Proper professional practice presupposes the need to make ethical judgements as well as to apply technical or scientific expertise. Professionals are self-determined and act on their own well formulated decisions.

David Ozar states that one has undertaken certain obligations in order to be a member of a profession. He then goes on to list seven categories of professional obligation.

1. Every profession has a chief client or clients whose well being the profession and its members are chiefly committed to serving.
2. There is a relationship between the professional and the client. The point of this relationship is to bring about certain values for the client which cannot be achieved without the expertise of the professional. Bringing about these values will require both the professional and the client to make a number of judgements and choices together.
3. Every profession has central values and each profession focuses only on certain aspects of values which contribute to the well being of its clients.
4. Every professional is obligated both to acquire and maintain the expertise needed to undertake his or her professional tasks and perform only those tasks in which he or she is competent.
5. The activities of every profession involve relationships between both the profession as a group and its members and the larger community as a whole or various significant subgroups of it.
6. Every profession has norms usually largely implicit and unstated concerning the proper relationship between members of the profession.
7. In most professions' Codes of Ethics, priority of service to the public is given prominent place.¹¹

The **CDHA Code of Ethics**¹² addresses responsibilities to clients:

The dental hygienist, as a member of the dental profession, is obligated to take steps to ensure that the client receives competent ethical care.

- 4(a). The dental hygienist actively promotes educational and clinical procedures to improve the oral health status of clients.
- 5(a). Client care should represent a collaborative effort, drawing on the expertise of dental hygiene, dentistry and other health professions when appropriate. Recognizing personal and/or professional limitations, the dental hygienist refers clients who require more complex care or care outside the scope of dental hygiene care.
- 5(b). The first consideration of the dental hygienist who suspects incompetence or unethical conduct by members of the dental profession should be the welfare of present clients and/or potential harm to future clients.

Dental hygienists should refrain from making any disparaging comments, about the qualifications or procedures of another dental hygienist or dentist. Such criticism should be directed in private to the colleague concerned and then, if necessary, to the appropriate professional body.

The promotion and delivery of oral health care requires a collaborative approach centering on the needs of the patient. Dentistry and dental hygiene should be partners in this endeavour. Dentists and dental hygienists must be willing to listen and learn from each other, rather than relying on emotion and retaliation.¹³

Dental hygienists will be responsible for discussing with other professionals appropriate process of care of the client. This will require better communication skills and listening skills, in order to dialogue with co-professionals on a regular basis, not just in time of crisis.

So far as ethics have evolved all ethics rest upon a single premise; that the individual is a member of a community of interdependent parts. One's instincts prompt one to compete for a place in that community but one's ethics prompt one to co-operate (perhaps in order that there may be a place to compete for).¹⁴

Total quality improvement

Each dental hygienist in a self-regulating jurisdiction will be accountable for service provided. The CDHA Code of Ethics addresses this:

- 4(h) Dental hygienists should engage in continuing education and in the advancement of skills relevant to the practice setting.
and
- 4(f) Research is necessary for the development of the dental hygiene body of knowledge. Dental hygienists should be knowledgeable of the advances in research so that established results may be incorporated into practice. Dental hygienists are encouraged to engage in, or to assist and encourage, research designed to enhance the health and welfare of clients.

How will dental hygienists participate in total quality improvement? How will the registrants pursue excellence? A professional person is one who has earned the right to life-long learning. The self-governing

climate can provide individuals with learning mechanisms to meet individual needs for self-appreciation, achievement and affiliation. Opportunities for personal growth and development are powerful motivators and these can be attained through appropriate courses designed or obtained through the Provincial Colleges of Dental Hygienists. Courses will be developed to assure dental hygienists are current in their knowledge and 'up-to-date' in their techniques.

What an opportunity for innovative methods of learning! Programs can be designed in such a way that they are easily accessible and self-paced for the registrants. The programs ought to be developed in such a way that the learning is fun and the activity enjoyable. With increased knowledge will come increased self-confidence, self-appreciation and self-caring.

Once dental hygienists feel good about themselves, learn how to appreciate themselves, become self-confident, sure in their knowledge and procedures, and have the support of their own College (which ought to provide an open and caring atmosphere for learning), they will be empowered to discuss clients' needs with the clients and dentists. With confidence and knowledge the dental hygienists can move to a climate of self-appreciation, self-respect and mutual respect for colleagues, to true professionalization.

When dental hygienists consistently implement what is learned through educational programs, the quality of client care will continually improve. Also, dental hygienists will gain increased recognition as valuable, committed health professionals.

It is to the benefit of the client that dentists and dental hygienists respect and care for each other and provide mutual support. The strengths of the two professions can complement each other for the betterment of the public.

Regulatory Colleges of Dental Hygienists can promote an environment which empowers their registrants to prepare for societal changes and to practise ethically and competently. Through extensive peer interaction, visions will be conceptualized, knowledge will be shared, ideas will be acted upon on behalf of society as a whole.

The dental hygienist's understanding of his or her value to the community will expand:

to assist clients in meeting their human needs through the performance of those oral health behaviours and practices which will lead to optimum wellness and quality of life, throughout the life cycle.¹⁵

Empowered through autonomous regulation dental hygienists will appropriate, unto themselves, the positive traditions of community health education, and professional collaboration in order to provide mechanical, technical and humane dental hygiene services in the twenty-first century. 

References

1. Motley WE. **History of the American Dental Hygienists' Association 1923-1982.** ADHA, Chicago. 21, 1983.
2. Darby M. **Theory Development and Basic Research in Dental Hygiene.** School of Dental Hygiene, Old Dominion University, Norfolk, Virginia. 51, 1990.
3. Leopold A. **A Sand County Almanac: And Sketches Here and There.** Oxford University Press, New York. 202, 1949.

4. Abbey-Livingston D, Kelleher D. **Managing for Learning in Organizations**. Ontario Ministry of Tourism and Recreation, Toronto, 1988.
5. **Webster's New World Dictionary**. Toronto, 214, 1970.
6. Roach Sister M. **The Human Act of Caring: A Blue Print for the Health Professions**. Canadian Hospital Association, Ottawa, 1987.
7. May R. **Man's Search for Himself**. N.W. Norton and Co., New York, 41, 1953.
8. Roach Sister M. **The Human Act of Caring**, 7.
9. Bassett S. **Can Dent Hyg/Probe**, 26:2, 1992.
10. Fligel DC, Maundrell RE, Rabb JD. Dental Dilemmas and Professional Autonomy. **Ontario Dentist**. July/August 1992.
11. Ozar D. Ethics for the Practicing Dentist, A Framework for Studying Professional Ethics. **J Am Coll Dent**. 58:1, 1991.
12. The Canadian Dental Hygienists Association's **Code of Ethics**, June 1992.
13. Darby M. Collaborative Practice Model. The Future of Dental Hygiene. **Can Dent Hyg/Probe**. 23:2, 1989.
14. Leopold A. **A Sand County Almanac**. 203-4.
15. Darby M. **Theory Development and Basic Research in Dental Hygiene**, School of Dental Hygiene, Old Dominion University, Norfolk, Virginia. 49, 1990.

Lynda Mickelson is presently Chair of the Transitional Council of the College of Dental Hygienists of Ontario. She is also pursuing sociological research of dental hygienists after actively practising for over twenty-five years.

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Self-regulation in Alberta, Canada: *The Achievement of a Goal*

FEATURE

By: **B. Walker, RDH, J. Juchli, RDH, BEd,**
and **J. Pimlott, RDH, MSc,** Alberta Dental
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Since their inception, dental hygiene associations world-wide have been committed to achieving recognition of dental hygiene as a "profession", with the ensuing goal of realising self-regulation. Self-regulation has been achieved in several geographic areas — the Province of Alberta being one. The purpose of this paper is to present the Alberta Dental Hygienists' Associations' perspectives on the achievement of self-regulation.

History

The Alberta Dental Hygienists' Association (ADHA) was registered under the Government of Alberta's *Societies Act* in 1965 and the Association made its first formal request for recognition as a profession in the late sixties.

Through the 1970's and the 1980's the ADHA worked unsuccessfully with legislative planners, the Alberta Dental Association and the Alberta Dental Assistants Association on several different forms of legislation that ranged from proposed amendments of old Dental Acts to newly created umbrella acts which were designed to include a variety of health groups.

A major stumbling block with all of the proposals presented to the ADHA was the fact that none of the proposals gave dental hygienists a majority representation on the boards or committees that determined entry to the profession, practice standards, and discipline. The governing boards proposed in these early drafts were always weighted heavily with either dentists or physicians. Since the ADHA would not accept

such proposals and no consensus amongst the professions could be reached, the Government called a moratorium on all professional legislation.

In early 1984, the Government of Alberta began drafting the concepts for a systematic approach for the regulation and control of standards pertaining to professions and occupations. The primary reason stated was "to protect the public against incompetence and fraud that would endanger the life, health, welfare, safety or property of citizens." The proposed concepts indicated that self-government would be a privilege delegated to a professional or occupational group by the Legislature only when it was clear the public could best be served by delegating this authority.

In 1990 the Provincial Government approved and published the final draft of its "Principles and Policies Governing Professional Legislation in Alberta". The dental assistants were the first group to lobby for self-regulation under this new policy, followed by the dental hygienists and the dental technicians.

The primary premise for the ADHA's request of this status was that public protection would be enhanced by maintaining professional standards of practise through regulation of registration requirements, definition of scope of practice, maintenance of currency through continuing education, and activation of a complaint and discipline mechanism. The second premise was based on the fact that one profession or occupation should not be regulated and controlled by another, as was the case in the previously existing legislation under the *Dental Professions Act*.

Throughout the many years of legislative negotiations the ADHA remained firm on a number of positions.

1. Self-governance was the goal. Dental hygienists did not want to be controlled by another professional body — particularly one that was made up of their employers.
2. ADHA was willing to accept umbrella legislation *only* if each group was allowed to have separate Regulations to determine entry to practice, practice standards, and discipline.
3. Majority representation on the controlling board or committees established by any new legislation was a must.
4. Independent practice was not a leading issue.

Steps Toward Self-Regulation

The ADHA proceeded with a series of steps that appear to be common to the majority of groups seeking self-regulation. The following discussion will highlight the steps taken as well as the issues to be considered and some of the outcomes of self-regulation as experienced by the ADHA.

Following the confirmation that the majority of ADHA members were supportive of self-regulation, an ADHA spokesperson was appointed to meet with government and other allied professional groups. This person represented the Associations' best interests and was capable of negotiating in a nonadversarial manner. The spokesperson presented the issues not only to the dental hygiene membership, but also to the dental association, the politicians and the bureaucrats. Through formal and informal submissions, it was necessary to convince all groups that self-regulation for dental hygienists would have a positive effect not only on the profession of dental hygiene but also on the dental health and protection of the public.

In 1990 the Association initiated another formal proposal for self-regulation with various levels of the Alberta Government and other agencies. Once the formal proposal had been submitted to Government, elected politicians were contacted by a letter writing campaign from their constituents. It is known that 20 to 30 letters regarding the same issue will often cause a politician to take serious notice of the issue. It is also advantageous to present the issues to the bureaucrats, the salaried government employees who often stay on through several changes of elected political officials. In the ADHA experience, these individuals were extremely important to the Association's efforts. The bureaucrats were provided with a formal statement of the Association's position. ADHA requested their cooperation and maintained continuous contact and input into the decision making process regarding dental hygiene legislation.

The next stage of discussion involved the Alberta Dental Association. Many dental associations equate self-regulation with independent practise. Therefore, the aim of the ADHA was to convey that self-regulation is mutually beneficial.

Preparation for Government Scrutiny

Once the proposal for self-regulation had been developed, the ADHA prepared for close Provincial Government scrutiny and assessment of the Association's readiness for self-government. Some of the

areas examined by the Alberta Government were:

1. The ratio of membership in the professional association compared to the total number of persons engaged in the practise of dental hygiene in the province.
2. The length of time the Association had existed and the availability of a comprehensive history of the ADHA. Complete membership numbers, organizational structure, and educational and training functions provided by the Association must be retrievable from accurate records.
3. Financial records demonstrating the Association's fiscal accountability were made available.
4. Assurance that the organizational structure of the Association would not crumble if it were to be granted the additional burdens and obligations which come with self-government.
5. Strength of volunteer participation from the ADHA membership was assessed. Additional members were required to sit on a discipline committee, a practice review board, a refresher education committee, while current committees of the Association continued to function.
6. The desire of the Association to become self-governing had to be continuously reaffirmed.

Once the stability of the Association's organizational structure was established, it was necessary to meet with legislative planners to discuss a wide range of issues that would be the foundations for the self-regulatory framework. Prior to the actual drafting of the legislation, the Alberta Government's legislative planners had to be made aware of the Associations' proposals and reasons for such proposals regarding dental hygiene regulation. The following listing provides a brief summary of the key issues that ADHA addressed. The pros and cons of these issues and questions arising from them were given very serious consideration.

1. Statutory Committees

The structure, function and composition of Statutory Committees created by legislation were considered. Key questions asked were in regard to the degree of public representation on ADHA committees.

2. Code of Ethics

The Code of Ethics would be required to meet current government principles and policies. It is likely that the ADHA will incorporate aspects of the CDHA Code of Ethics.

3. Scope of Practice

Either a listing of allowable duties or a broad definition of dental hygiene practice could become the basis of the Scope of Practise. The ADHA's goal is to develop a progressive and functional definition.

4. Supervision

Supervision will be defined in the ADHA's Regulations. It may be described in general or specific terms. A supervisory statement should support improved access to dental hygiene services.

5. Regulatory Body

There were two alternatives for the structure of the regulatory body:

a College of Dental Hygiene separate from the Professional Association; or a Professional Association that accepts the dual responsibility of regulation and professional advocacy.

6. Registration and Renewal

The Government of Alberta's Dental Disciplines Act makes ADHA membership a requirement for registration and renewal. Current ADHA by-laws support concurrent membership in ADHA/CDHA. Drafts of ADHA by-laws under the *Dental Disciplines Act* make provision for additional renewal requirements.

7. Fees

Fees reflected the increased costs of self-regulation and were determined by means of careful and realistic budgeting.

"As a self-governing profession, ADHA has gained public credibility and respect."

Outcomes of Self-regulation

The *Dental Disciplines Act* was proclaimed in force on November 1, 1990. This umbrella act for dental hygienists, dental assistants and dental technicians was the most expedient and cost effective method of meeting the immediate needs of the three allied groups. It has been written to insure the independent and totally separate functioning of each professional Association in its regulatory and business capacities.

The Provincial Governments' concern for public protection was the major factor in its decision to grant self-regulation to dental hygienists in Alberta. The public now has direct access to an office for dental hygiene information as well as a direct avenue for voicing concerns. There are voting public representatives on decision making councils and committees within the Association. As a self-governing profession, ADHA has gained public credibility and respect.

Government involvement has increased dramatically. The ADHA has been included in numerous government surveys, task forces, and working groups dealing with the creation of health policies for the province. This relationship between government and dental hygiene was non-existent prior to self-regulation. Previously, the Alberta Dental Association was the only dental group consulted regarding health or manpower issues.

There are also a number of very positive and visible consequences of self-regulation in regards to our members. There has been an obvious increased interest in ADHA activities and a greater pride in the association and the profession. Voluntarism is up, as is registration at continuing education courses even though mandatory continuing education is not yet a requirement for licensure renewal. The ADHA office is well utilized as an information and resource centre on everything from current aseptic techniques to labour relations. Of course, on a slightly less positive note, there was an immediate and substantial fee increase for our members in order to support the increased costs of self-regulation.

The relationship between a newly created self-governing provincial association and the existing national advocacy body may need to be redefined. Once again the situation should be looked at as beneficial to both parties. ADHA will develop a new Mission Statement that will incorporate the basic principles of the CDHA Mission Statement into

those of the ADHA regulatory body. It is also likely that the CDHA's newly approved Code of Ethics will be the basis for the ADHA Code of Ethics.

One of the goals following achievement of self-regulation was to improve the relationship between the Alberta Dental Association and the ADHA. Presently, non-voting observers sit on each others Board of Directors. Continued dialogue will improve the rapport and trust between the two groups.

Following the proclamation of the *Dental Disciplines Act*, the ADHA requested and was granted voting representation on key committees within the Division of Dental Hygiene and the Faculty of Dentistry at the University of Alberta including Faculty Council, Admissions and Curriculum Committees. This involvement will allow the ADHA to have increased input regarding the entry level to dental hygiene practise, the development of a baccalaureate program and the implementation of expanded duties.

Conclusion

The successful Alberta experience was the result of tireless devotion spanning nearly three decades, as well as a recent change in Government philosophy regarding professional regulation and self-determination. As the public and stakeholders needs and perceptions of dental hygiene practice undergoes changes, the Regulations and By-laws of the ADHA will be altered. Self-regulation will indeed be a "balancing act" as the practise of dental hygiene continues to evolve.





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in conjunction with
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MOVING WITH THE 90'S

Collaboration of Health Care Professionals: The Dental Hygienists' Role

By: *Laura MacDonald, RDH, BScD (DH), MEd*

Abstract

Dental hygienists are primary health care professionals concerned with oral health and general well-being of the public. This paper discusses collaboration amongst the health professions to further the wellness of Canadians.

Introduction

Health promotion is the process enabling people to increase control and improve their health through self-care, mutual aid and the creation of healthy environments.¹ The role of the health care professions and health care givers is to enhance this process. Integral to the process is a collaboration amongst health care providers. The CDHA Management of Dental Hygiene Care Position Statement states: "CDHA supports collaborative practice wherein a partnership exists between dental hygienists and other health care professionals participating in the delivery of comprehensive oral care".² This statement can be expanded to include comprehensive health care in general. Dental hygienists can be proactive in accepting the challenge of educating other health care professionals and the public with respect to collaborative health care delivery and/or practice.

A Segmented Health Care System

Health professionals tend to segment themselves into categories: nurse, occupational therapist, dental hygienist, physician and others. For example, physicians and nurses tend to the needs of the hypertensive public and as well to preventive efforts related to hypertension (such as blood pressure clinics). The dental hygienist and dentist assume the service provision for the 20% of the population who have periodontal disease.³ In order to provide quality care, it is good that such expert services are available to the public. The whole system, however, would be better able to provide such service if more collaboration was stressed amongst the providers.

Collaboration

Health professionals should be collaborating with each other through open dialogue to facilitate a higher quality of life for the individual, and the community as a whole. They should be knowledgeable and able to provide scientifically sound information, or at least know of and use reliable sources, when providing care to the public. Health professionals can also help each other in that provision especially through non-traditional settings. These sources should not only relate to medical and dental professional resources, but also to social and community



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outreach self-help and mutual aid groups. Mutual aid and collaboration among health professionals and other resources keeps the best interest of the public at the forefront.

Non-traditional Settings

Collaboration between professionals can exist by offering services to the public within currently non-traditional settings. Doing so would necessitate continuing education for non-traditional care givers, such as dental hygienists, physicians or nurses providing tobacco-use cessation programs or oral health cursory examinations, respectively. How much attention is directed in the medical office for screening of oral disease? How many dental

offices screen routinely for persons with hypertension?

Blood pressure screening in the dental office not only serves the purpose of providing quality care to the patient, but it also works towards the efforts and goals pertaining to this condition.^{4,5} A large number of individuals with hypertension have not been diagnosed, counselled or treated. It is possible to reach these unaware and undetected individuals, by increasing the chances that they will be identified and treated appropriately. The individual client benefits in that he/she would become aware of blood pressure, and would then be more informed regarding his or her health status. The oral health care professional would be provided with important health variables contributing to the overall treatment plan and prognosis of the individual patient. Thirdly, it serves as a screening mechanism for persons with cardiovascular disease and a referral point of entry into the necessary medical intervention.

Given the promotion of the oral health team's role in a cardiovascular risk factor reduction program, what is the attitude of physicians and dentists regarding this non-traditional setting? Young, Karp and Karp (1990) report: (1) that dentists tend to have a more positive attitude than physicians about performing blood cholesterol screening in the dental office and (2) but that both dentists and physicians express positive attitudes regarding the dental office as a blood pressure screening facility.⁶ However, little over one half of the dental personnel have received formal education on blood pressure measurement.⁵ Therefore, despite a positive attitude toward blood pressure screening in the dental office, it is not surprising that this procedure is not routinely performed in this health care facility. Both Canada and the United States have initiated position statements to encourage dental offices to incorporate blood pressures screening into the regular care of all patients.

The dental hygienist can act as an advocate for promoting blood pressure screening on all clients. This may be accomplished through staff meetings, continuing education sessions, or simply ordering blood pressure units for the office.

Oral disease screening can take place in the medical office via a cursory intraoral examination of the dentition and periodontium. This may occur in some practices, but how prevalent is such practice in the medical office? Oral diseases, such as periodontitis and dental caries, are not generally life and death conditions, but they do have an impact on one's quality of life.⁷⁻¹¹ Screening for oral disease in the medical office offers the public another opportunity to identify conditions that affect their wellness. The dental hygienist can offer to hold workshops for medical practitioners and health care givers on the signs and symptoms of oral disease, how to prevent it, and how to promote oral health.

Diet has an impact on leading health problems, such as cardiovascular disease, stroke and diabetes. Yet, how many dental offices and medical offices employ a dietician or a nutritionist? These health professionals offer vital information and skill acquisition to promote sound nutrition practice. Although dental hygienists are educated in nutritional counselling, their area of expertise lies in counselling regarding dental caries. Dental hygienists are not nutritionists, unless they have earned that title.

Elbon and Karp (1987) reported on the effectiveness and acceptance, as well as cost implications of the dietician as a member of the oral health team.¹² They stated that the need for nutritional education and skill development is not being met, but some of it could be if the dental office employed a dietician. Given the reality of some dental practice settings, it may not be feasible to employ an on-site nutritionist, but the dental hygienist could make referrals and certainly could initiate preliminary discussion on nutrition as it relates to general health.

***"All health professionals should recognize...
the role of other health promotion resources
and programs in the community."***

Messages between health care professionals should not conflict with one another. When a dental hygienist is discussing dentally nutritious food choices, does she/he consider the nutritional soundness of the food product? Potato chips may be an acceptable food choice, dental-wise, but they are not a recognized health-wise choice. The dental hygienist must be aware of the nutritional recommendation in context of the person's life circumstances. It is much easier to spell out the "should's" and "should not's", than to place those in their correct context which often creates the "grey fuzzy areas". Similarly, is the nutritionist aware of the oral health status of the individual or group, he/she is working with. Ill-fitting dentures can create eating problems, and deter people from making healthy food choices. Just as the oral health practitioner could make referrals to a nutritionist, the nutritionist could make referrals to the oral health practitioner. Interaction among the professions serves to improve the total care of the individual providing food for thought. This may even result in the client seeking more information and activity towards self-care.

Another non-traditional activity is that of tobacco-use cessation programs offered through the oral health care office, and not just in medical practices and specialized clinics. It is important, however, to practise what you preach; the oral health care clinician presents a role model for the patient. Fried and Rubinstein (1990) found that of 397/500 dental participants, 6.9% reported that they smoke, 26.3% said they formerly did and 66.8% stated they never smoked.¹³ In this same study, 17.1% of

the subjects reported that at least one dentist in the practice smokes and 55.7% said that at least one other staff member did so.

Do dental hygienists advocate for tobacco-use cessation campaigning through the dental office? Fried and Rubinstein (1990) indicate that they do, reporting that more than 50% of the subjects stated that they "almost always" or "often" performed the practice behaviours of advocating smoking cessation.¹³ These dental hygienists even felt that they should participate in community anti-tobacco presentation and legislation. This study presents a positive picture of the role of health professionals in health promotion in the community.

All health professionals should recognize and have basic information on the role of other health promotion resources and programs in the community. The oral health practitioner when performing an intra- and extra-oral examination may be the first professional to identify the physical symptoms of an abused victim. It is in the client's best interest for the oral health care worker to be able to refer the client to a community resource such as a crisis telephone hotline or shelter. Knowing that others care may be the first step for the victim. Offering the means to seek further assistance may be of great benefit.

Inter-disciplinary Advocacy

Part of collaboration is inter-disciplinary advocacy on behalf of all health professions' efforts to improve health care for the public. Support for the initiatives of other health professions comes about by educational activities that bring the issues to attention, and fosters colleagues' interest in health care. For example, social and community workers and medical clinicians supporting the inclusion of dental offices within community health clinics; dental hygienists promoting the implementation of a dental clinic based tobacco-use cessation program; and institutional health care providers, as well as the residents, subscribing to relaxed supervision requirements on the practice of dental hygiene. The outcome of the latter would mean improved access to less costly dental care.¹⁴ Dental hygienists could be employed within government programs reaching out to rural areas (typically under serviced) and socio-economically deprived groups.^{15,16} Such legislation would enable "more people to have the opportunity to learn how to achieve and maintain their oral health through self-help and preventive techniques combined with professional care as required".¹⁶

The individual dental hygienist, and collectively through associations, needs to assume responsibility for lobbying for the relaxation of supervision requirements on the practice of dental hygiene and the promotion of self-regulation. These then could become a reality. Dental hygienists need to step outside the clinic walls and into the community, offering oral health education sessions to a variety of so-called movers and shakers (nursing associations), decision-makers (board members of a residential home for the elderly) and the public, in general (community meetings). Let the health professional and public community know of the professionalism of dental hygiene and the services that dental hygiene has to offer the public. The greater the exposure of the dental hygienist as the primary oral health educator, the greater the likelihood of dental hygiene practice broadening its work place opportunities based on demand by the public and decision-making forces.

Service Based on Scientifically Sound Fact

Even within the dental health profession, there is a need for continuing education to keep up-to-date of advancement in the oral health

field. Did you know : 1) Oral health-wise, Capilouto and Douglass (1988) report that people are retaining their natural dentition.² These retained teeth could be considered at risk to periodontal destruction, thus leading to an increase in the incidence of periodontal disease; 2) However, trend analysis projects that the overall prevalence and severity of both gingivitis and periodontitis is decreasing;² 3) Although most people have had or have gingivitis, current dialogue suggests that gingivitis, chronic or acute, may or may not develop into periodontal disease;¹⁷ and 4) Further investigation is required as to why periodontal disease affects some, but not others; as well, whether gingivitis is a precursor to periodontal disease, are they one and the same disease entity or mutually exclusive.^{2,17}

Related to the issue on aging is the anticipation of an increase in root caries incidence due to the retention of the natural dentition. Leske and Ripa (1989) pose that prior to jumping to this conclusion, further investigation is required, as they demonstrated that morbidity associated with root caries in adult populations was not high.¹⁸ Should health professionals advocate community fluoridation, not just for the sake of the youth, but also because of the known benefits derived by the older populations concerning coronal and root caries?¹⁹

"Perhaps it is necessary for the dental professions to reflect on their own attitudes and approaches to health care, prior to feeling neglected by the health care system."

Attitude of Oral Health Professionals

The last issue to be discussed in this paper is the general concern that oral health is not seen by the public and health professions as an important aspect of total health. Perhaps this perceived lack of concern is partly the fault of the oral health profession for not getting the most up-to-date, scientifically sound message across to the public. In an opinion study, it was found that the general public emphasize regular dental visits and tooth brushing, as opposed to diet and fluoride, as most influential to their oral health.²⁰ The dental profession ranked good oral hygiene ahead of regular dental visits, and this was followed by proper diet and the use of fluoride. Both the public and the dental profession placed emphasis on the dependency of regular dental visits and did not stress the well-founded anti-cariogenic effect of fluoridation and the use of other systemic and topical fluorides.

O'Neill (1984) states that there is a need to reduce the technology transfer lag between researchers, practitioners and the public.²¹ He found a definite difference between the dentist who relied on a theoretical approach (efficacy of tooth brushing and diet) versus the research community who were more realistic (people are not likely to stick to a strict diet or brush immaculately) in their advocacy for water fluoridation and the use of fluoridated products. On a practical note this is disturbing as Lang, Woolfolk and Faja (1989) report that elementary schoolteachers, who teach the dental curriculum content, rely heavily on information gathered at the dental office.²² Their information was incorrect, resembling that of the findings of O'Neill (1984)²¹ and the Opinion Research Corporation (1983).²⁰ Lang et al. (1989) restressed that there is indeed a gap between public knowledge and scientific foundation.²²

Just as there is difficulty in unplanned and planned change within the public sector, there appears to be a struggle within the oral health profession to accept new findings and adopt new practices. The oral health profession prides itself on its historical acclamation of a discipline that promoted the preventive science of oral disease, as well as health education principles. However, Russel, Horowitz and Frazier (1989), reporting on a school-delivered oral health program, felt that although the children were provided with information about/on achieving of oral health, there was a lack of the "why's" and "what for's" when services were being delivered, hence the purpose and value became lost.²³ Nettleton (1989) reported that the dental profession perceived that the barrier to the educational process was the patient's lack of receptiveness (the patient was seen as the problem).²⁴ Furthermore, it was believed that patients were best to adopt the practice that was in accordance with the professional opinion. This attitude reflects a paternalistic approach to health care, an old school thought. Paternalism inhibits the client from making informed choices and erodes the concept of health promotion.

Perhaps it is necessary for the dental professions to reflect on their own attitudes and approaches to health care, prior to feeling neglected by the health care system.

Recommendations

The following are recommendations generated from discussion in this paper:

- surveillance regarding the knowledge, attitude, beliefs and behaviours of health professionals about each other's disciplines (treatment, prevention and promotion activities);
- surveillance regarding the performance of screening programs in non-traditional settings (e.g., blood pressure screening in the dental office), as well as the interest and willingness to implement these programs.
- promotion of forums for exchanging of information, practice and expectations between researchers, practitioners and the public;
- conduction of regular interdisciplinary workshops amongst — health care professionals (e.g., tobacco-use cessation campaigning);
- adoption of position statements on health promotion by all health associations and educational institutions;
- emphasis of collaboration and health promotion within the educational curriculum;
- assurance that oral health will be included in any comprehensive health study (Clovis (1987) criticizes that it was not an item in Canada's Health Promotion Survey conducted in 1985²⁵);
- advocacy by all health professionals for the employment of health care professionals in non-traditional settings (e.g., dental hygienists in nursing homes);
- advocacy for the continuance of government programs related to dental health delivery and expansion to include disadvantaged groups;

- introduction of innovative means for reaching all people regarding prevention and promotion strategies to be used in the pursuit of health and high level wellness;
- collaboration amongst health professionals with emphasis on awareness and interaction so as to better serve the public.

Summary

With collaboration between the health professions and the community, the health care system would be a proactive system contributing the health and wellness of the people it serves. All health professionals have a responsibility to being informed on the issues and advancements in the others fields, so that the public will benefit from a more balanced approach to health care. This balance will serve as a role model for individuals and the community striving towards self-care, mutual aid and a healthy environment. 

References

1. Epp J. Health and Welfare Canada. **Achieving Health for All: A Framework for Health Promotion**. Supply and Services Canada, Ottawa, 1986.
2. Canadian Dental Hygienists Association Management of Dental Hygiene Care, Position Statement, June 1992. **CDHA Jour/Probe**, 26(3): 100, 1992.
3. Capilouto M & Douglass C. Trends in the prevalence and severity of periodontal disease in the United States: a public health problem. **Jour of Publ Health Dent** 48: 245-251, 1988.
4. Co-ordinating Committee of the National High Blood Pressure Education Program. Collaboration in high blood pressure control: among professionals and with the patient. **Annals of Internal Medicine** 101: 393-395, 1984.
5. Ramaprasad R, Carson P, Congdon E, Barta P & Ziskin L. Dentists and blood pressure measurement: a survey of attitudes and practices. **JADA** 108: 767-771, 1984.
6. Young S, & Karp W. Dentists and physicians attitudes on the role of the dental health care team in a cardiovascular risk factor reduction program. **Jour Publ Health Dent** 50(1): 38-41, 1990.
7. Nikias M. Oral disease and quality of life. Editorial. **Amer Jour Publ Health** 75(1): 11-12, 1985.
8. Locker D & Grushka M. Prevalence of oral pain and discomfort: preliminary results of a mail survey. **Comm Dent Oral Epidem** 15: 169-172, 1987.
9. Locker D & Slade G. The prevalence of symptoms of TMJ disorders in a Canadian population. **Comm Dent Oral Epidem** 16: 310-313, 1988.
10. Reisine S & Weber J. The effects of TMJ disorders on patients' quality of life. **Comm Dent Healt** 6(3): 257-270, 1989.
11. Ekelund R. Dental state and subjective chewing ability of institutionalized elderly people. **Comm Dent Oral Epidem** 17: 24-27, 1989.
12. Elbon S & Karp W. The dietitian as a member of the dental health care team. **Jour of Amer Diet Assoc** 87: 1062-1063, 1987.
13. Fried J & Rubenstein L. Attitude and behavior of dental hygienists concerning tobacco use. **Jour of Publ Health Dent** 50(3): 172-179, 1990.
14. Report of the Working Group on the Practice of Dental Hygiene. Executive Summary and Recommendations, March 1986, Government of Canada, Dept. of National Health and Welfare.
15. Brownstone E. The role of dental hygiene in health promotion. **CDHA Jour/Probe**. 21(4): 164-168 1987.
16. Gallagher D. The role of the dental hygienist in achieving health for all. **CDHA Jour/Probe** 21(3): 119-122, 1987.
17. Burt B. Public health implications or recent research in periodontal disease. **Jour of Publ Health Dent** 48: 252-256, 1988.
18. Leske G & Ripa L. Three year root caries increments: implication for clinical trials. **Jour of Publ Health Dent** 49(3): 142-152, 1989.
19. Hunt R, Eldredge J & Beck J. Effect of residence in a fluoridated community on the incidence of coronal and root caries in an older population. **Jour of Publ Health Dent** 49(3): 138-141, 1989.
20. Opinion Research Corporation. Dental caries; what people know: surveying the knowledge gap. Study conducted for the MARS Corporation. 1983.
21. O'Neill H. Opinion study comparing attitude about dental health. **JADA** 109: 910-915, 1984.
22. Lang P, Woolfolk M & Faja B. Oral health knowledge and attitude of elementary schoolteachers in Michigan. **Jour of Publ Health Dent** 49(1): 44-50, 1989.
23. Russel B, Horowitz A & Frazier P. School-based preventive regimen and oral health knowledge and practices of 6th graders. **Jour of Publ Health Dent** 49: 192-200, 1989.
24. Nettleton S. Dental and dental hygiene education: a study of the perception of 28 community dentists. **Comm Dent Health** 6: 47-59, 1989.
25. Clovis J. The Active Health Report — perspectives on Canada's health promotion survey. **CDHA Jour/Probe** 21(4): 161-168, 1987.

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SUPPLIED: Viadent Anti-Plaque Oral Rinse: Bottles of 500 mL.
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Dental Hygienist as Supervisor in a Community Health Setting

By: Shirley Bassett, Dip DH, BScD

It is an exciting time to be involved in community health in British Columbia. For the first time dental hygiene's philosophy of health is closely aligned with that of government. In B.C. a commitment to prevention has been made, including a shift in funding away from the treatment of disease to prevention.

Communities are being given the opportunity to identify their own problems, set their own priorities and develop their own solutions. As health care professionals we have an opportunity to assist them in identifying problems, helping them document issues, teaching them skills and helping them acquire the information needed to solve their own problems. In my mind, the over-arching mandate of dental hygienists has always been to empower people so that they can obtain optimum oral health for themselves. It is satisfying to be part of a health care system that is embracing this notion.

The Capital Regional District which employs me in their Health Promotion Program, offers health services to about 300,00 residents who live in the Victoria area (2,441 sq. kms).

Officially, I am the supervisor for the Dental Component, but in reality I am just one member of a team of three dental hygienists (all part-time), and one dental assistant (full-time). Together, we provide services to the public that fall into three general areas:

- screening kindergarten children to identify those with urgent needs and assisting their families to obtain the care they require;
- initiating and/or participating in multi-disciplinary health promotion activities; and
- providing resources and information so that



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others can carry out oral health activities and projects.

As the supervisor I participate on a management team which includes the Director of Health Promotion and program heads from other disciplines such as public health nursing, audiology, speech therapy, nutrition, health education and community development. Together we set common goals around which all of our disciplines can plan programs. At monthly meetings we discuss common health issues, epidemiological trends, budgets and staff training. Updates on each program are shared at this time. Meeting in this multi-disciplinary environment prevents "tunnel vision" over dental issues, and allows me to keep dental health in the context of general health where it belongs.

Within the dental program I am responsible for: program planning and evaluation; presenting the rationale for decisions made; developing and administering a budget; gen-

erating program reports, preparing written material on current dental issues; acting as the spokesperson for the dental program both internally and to the public; evaluating staff performance and assisting staff develop to their full potential through training and work assignments. Of course, the other dental staff contribute to, and support, these activities which is why our program runs so well. Four brains are indeed superior to one.

Being a community health dental hygienist reminds me a lot of being a student at university. It seems I never reach the point of knowing as much as I need, or want, to know. When I leave the office my work comes home with me, even if I leave my briefcase behind (projects and problems percolate in the back of my mind), and I learn something new everyday.

Working in the community environment is both challenging and rewarding. It requires vigilant monitoring of dental health and disease trends; skills in managing people, money and data; and good communication skills, both written and verbal. The rewards are in knowing we have assisted others to improve their health and in seeing staff grow and develop personally and professionally through their employment setting. 

Self-Assessment Test



SELF-ASSESSMENT

- The nutrients that supply the energy sources (calories) needed for body functions are:*
 - carbohydrates, proteins and vitamins
 - carbohydrates, proteins and minerals
 - carbohydrates, minerals and vitamins
 - proteins, minerals and fats
 - carbohydrates, proteins and fats
- A person with inflamed lips, sore tongue, angular cheilosis and scaly skin may be deficient in:*
 - vitamin C
 - vitamin B₂
 - vitamin E
 - vitamin K
 - vitamin A
- Which of the following statements regarding vitamin A is false?*
 - it plays a major role in vision, bone growth and maintenance of epithelial tissue
 - excellent sources are the colourful vegetables rich in beta-carotene (especially the dark green, yellow and orange ones)
 - it does not accumulate in the body so there is no chance of a toxic overdose
 - vitamin A and its derivatives are used for treating acne and wrinkles
 - vitamin A deficiency is the leading cause of blindness in some developing countries
- This is an essential co-factor in blood coagulation and is widely regarded as the "anti-osteoporosis" mineral:*
 - iron
 - calcium
 - phosphorus
 - magnesium
 - potassium
- High blood cholesterol is an indicator of risk for cardiovascular disease. Which of these statements regarding cholesterol is true?*
 - we get cholesterol from foods or by manufacturing it ourselves
 - cholesterol is part of every cell and is used to make bile and certain hormones
 - when a diet doesn't contain enough cholesterol our liver makes up the difference
 - food **fats** raise blood cholesterol more than food **cholesterol** does
 - all the statements are true
- Fat in reasonable amounts is not only good for us, but essential. Too much causes problems and there are several ways we can reduce both our total fat and saturated fat intake. Which of the following will not reduce saturated fat intake?*
 - using an air popper for popcorn
 - cutting down on animal foods, whole milk and pastries
 - using tub margarine labelled "soft" instead of stick margarine or butter
 - roast, grill, bake or stir-fry as much as possible. If you have to fry use a "non-stick" spray and frying pan
 - choosing meat cuts with fat marbled throughout the cut, i.e. T-bone steak, prime rib.
- On a food label look for ? or fewer grams of fat per serving for each 100 calorie serving:*
 - 2
 - 3
 - 5
 - 7
 - 8
- Sodium is a necessary mineral used by the body to maintain normal water balance inside and outside the cells but our diets often include more salt than is needed. Other than controlling what comes out of the shaker, which of these can we cut down on to restrict sodium intake?*
 - most canned and prepared soups
 - tomato-based products
 - processed luncheon meats
 - most cheeses
 - all of the above
- Increasing the amount of fibre in our diets has received much fanfare recently because it helps to maintain the health of the digestive tract and may reduce the risk of cardiovascular disease by lowering blood cholesterol. Which of the following is not a source of fibre?*
 - whole wheat bread
 - brown rice
 - vegetables and fruits with edible peels
 - meats
 - nuts
- To help preserve the vitamins in food which of the following statements is false?*
 - store canned goods in a cool place
 - keep milk cold, covered and away from strong light
 - trim or cut fruits and vegetables into small pieces as much as possible
 - whenever possible serve any liquid that is packed with the canned goods
 - refrigerate foods in moisture-proof containers

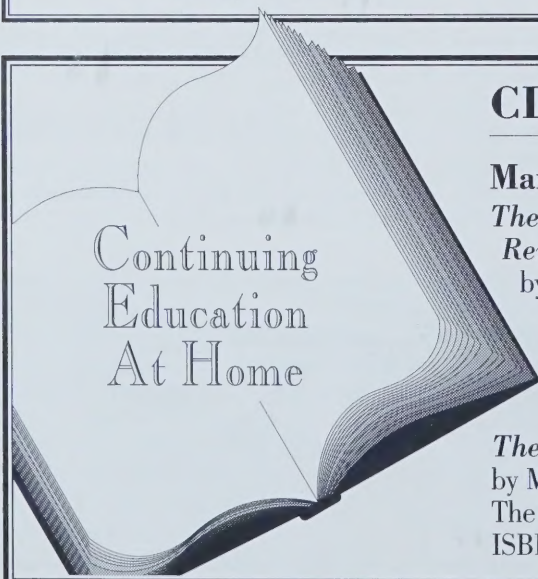
References

- Nutrition: Concepts and Controversies.** E. Hamilton, E. Whitney and F. Sizer. 5th edition, West Publishing Co., St. Paul, Minnesota. Copyright 1991.
- Contemporary Nutrition: Issues and Insight.** G. Wardlaw, P. Insel and M. Seyler. Mosby-Year Book Inc., St. Louis, Missouri. Copyright 1990.
- The Science of Human Nutrition.** J. Brown. Harcourt Brace Jovanovich Inc., Orlando, Florida. Copyright 1990.
- This self-assessment test was submitted by Diane Moore, SDT, RDH, Instructor, Dental Hygiene Program, The Saskatchewan Institute of Applied Science and Technology, Regina.*

Answers

1. e) Sources of vitamin B₂ or riboflavin are dairy products, meat, eggs, whole and enriched-grained products
2. b) Vitamin A is fat-soluble and not readily excreted. Heavy and regular consumption [especially high protein supplements] can cause toxic symptoms
3. c) Sources of calcium are milk, yoghurt and cheese.
4. b) The loin and round cuts are lower in fat and the fat should be trimmed before cooking.
5. c) 3 grams per 100 calories of food equals about 30 per cent of calories from fat — the general recommendation.
6. e) No meats or dairy products contain fibre. The greater the surface exposed the faster the vitamins break down by oxygen.
7. b) We also receive sodium in our diets from bottled water, many non-prescription medications and cooking with baking soda, baking powder and MSG.
8. e) No meats or dairy products contain fibre. The greater the surface exposed the faster the vitamins break down by oxygen.
9. d) iron
10. c) Sources of calcium are milk, yoghurt and cheese.

		LOCATION	FOR INFO CALL
April 1993			
2	Medical Emergencies — Beyond Basics	U. Washington	(206) 543-5448
3	Update on Radiographic Techniques	U. Manitoba	(204) 788-6331
14	Applied Pharmacology	U. Saskatchewan	(306) 244-5072
16-17	Period for the '90s and Beyond	U. Washington	(206) 543-5448
17	Update & Review of Radiology	U. Western Ontario	(519) 661-3631
17	Dentistry for Special Needs Patients	U. Alberta	(403) 492-5023
23	Clinical Course on Implant Maintenance	Edmonton (Le Marchand Mansion)	(403) 488-1240
24	Infection Control	Dalhousie U.	(902) 494-1674
24	"Brush up" on Issues in Dentistry	U. British Columbia	(604) 942-5785
27	Emergency Procedures in the Dental Practice (for dental professionals)	U. Toronto	(416) 979-4503
29-May 1	CDA Convention	Toronto	1-800-267-6354
May 1993			
8	Infection Control in Dentistry	U. Alberta	(403) 492-5023
15	Partnership Strategies in Periodontics for the '90s	Calgary U of C	(403) 492-5023
15	Ultrasonics in Periodontal Therapy: Past, Present, & Future	U. British Columbia	(604) 942-5785
15	Curvettes	Edmonton EDDS	(403) 464-0294
17	Conscious Sedation in Dental Practice	U. Alberta	(403) 492-5023
21	TMJ Dysfunction — Current Status of Diagnosis and Treatment	U. Washington	(206) 543-5448
27-30	ADHA Convention	Jasper	(403) 464-6266
30-June 3	Canadian Dietetic Association's Annual Conference	Toronto	(416) 596-0857
June 1993			
10-11	Root Planing Therapy	U. Alberta	(403) 492-5023
12-13	Enriching Clinical Competence: A root planing workshop	U. British Columbia	(604) 942-5785
20-25	Dental Hygiene Refresher Course	Dalhousie U.	(902) 494-1674
July 1993			
5-16	Dental Hygiene Refresher Course	George Brown College, Toronto	(416) 944-4556



CDHA's Book of the Month Suggestion

March:

The Human Act of Caring: A Blueprint for the Health Professions, Revised Edition

by Sister S. Simone Roach

The Canadian Hospital Association. Copyright 1992.

ISBN 0-919100-83-X

April:

The Regulation of Emerging Health Care Occupations

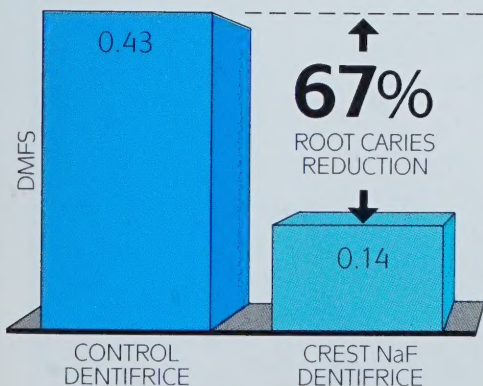
by M. Jane Fulton

The Canadian Hospital Association. Copyright 1988.

ISBN 0-919100-76-7



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age 40 have at least one carious or filled root surface lesion,² that's important to know.

So give your patients the clinically proven advantage against root caries that only Crest has been shown to offer. Recommend with confidence.

References: 1. Jensen ME, Kahout F: The effect of a fluoridated dentifrice on root and coronal caries in an older adult population JADA 1988, 117:829-832 2. 1985 NIDR adult oral survey Oral Health of United States Adults (1985-1986)

Crest

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*On exposed root surfaces

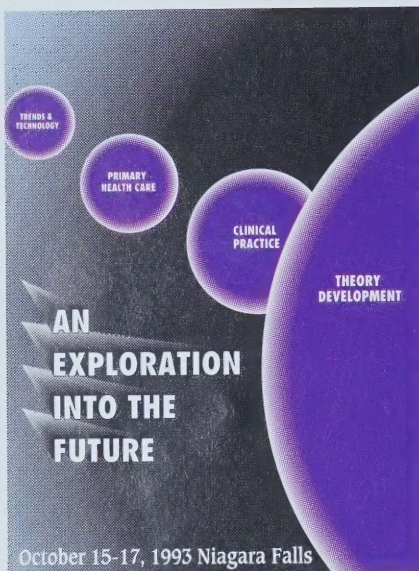


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PAAB
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CDHA Professional Conference 1993

To begin our exploration of the future, we are honoured to announce that Roberta Lynn Bondar will be the guest opening speaker on Friday evening, 15 October.



The complete
Conference
Program and
registration form
will appear in the
next issue of

PROBE.

Born and raised in Sault Ste Marie, Ontario, Dr. Bondar holds degrees in agriculture, experimental pathology, a PhD in neurobiology, a doctorate in medicine, and is a Fellow of the Royal College of Physicians and Surgeons of Canada, in neurology.

Dr. Bondar has devoted many years as a clinical and basic science researcher in the nervous system. While an undergraduate student, she worked for six years for the then Federal Department of Fisheries and Forestry on genetics of the spruce budworm, focusing on the visual system. Following her internal medicine internship at Toronto General Hospital, she completed post-graduate medical training in neurology at the University of Western Ontario, and in neuro-ophthalmology at Tuft's New England Medical Center (Boston), and at the Playfair Neuroscience Unit of Toronto Western Hospital. Dr. Bondar specialized in Carotid Doppler and Transcranial Doppler, at the Pacific Vascular Institute in Seattle, Washington.

Dr. Bondar's illustrious career soared to new heights in January 1992 when she flew on Discovery during Mission STS-42.

In 1983, Dr. Bondar was one of six Canadian astronauts selected for the NASA Space Shuttle program. She commenced astronaut training the following February.

Dr. Bondar was a principal investigator on a taste experiment flown on the Shuttle, and pioneered the investigation of cerebral blood velocity during weightlessness. She has represented Canada in the development of international collaboration over space life sciences research.

Dr. Bondar is continuing her space research with NASA as a Distinguished Fellow at McMaster University, and Distinguished Professor at Ryerson Polytechnical Institute.

Keynote Speaker

DR. JANE FULTON

**University of Ottawa,
Health Policy and Strategic
Management**

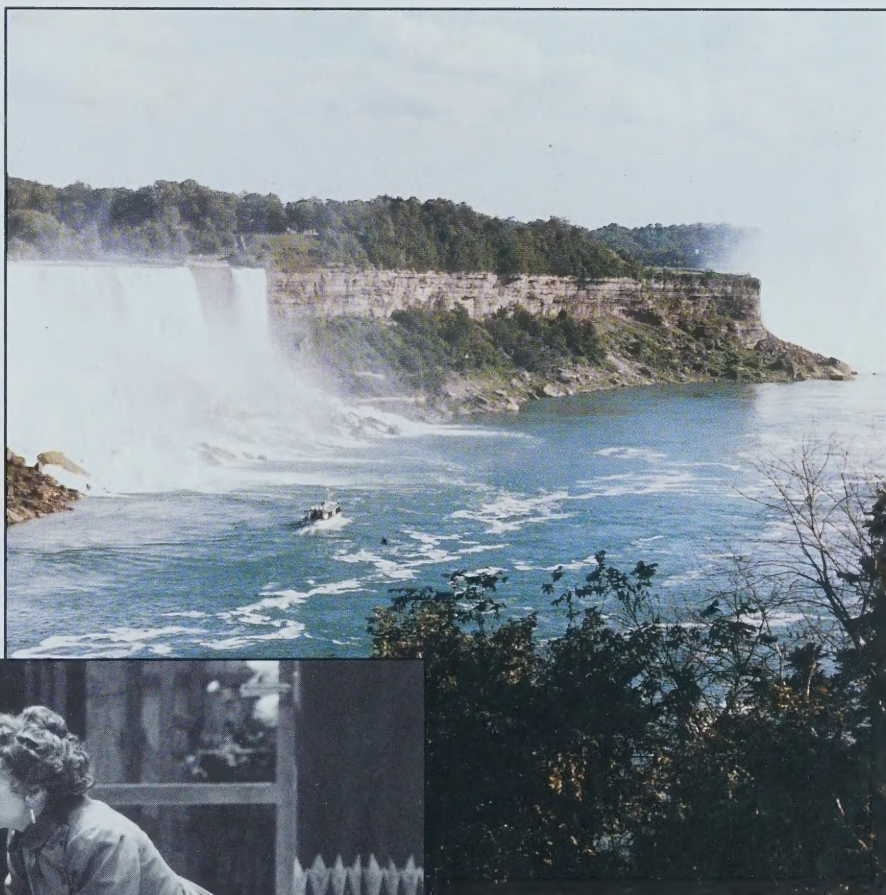
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To date over fifty abstracts have been received for the Conference from the USA — Texas, California, Iowa, Tennessee, South Dakota, Virginia, Ohio, Idaho, and Illinois, and Canada — British Columbia, Alberta, Ontario, Saskatchewan, and Nova Scotia.

Some of the confirmed speakers include: **Sharon Gravois, RDH**, San Jose, California; **Linda Kraemer, RDH, PhD**, Philadelphia, Pennsylvania; **Jacqueline Fawcette, PhD**, Storrs, Connecticut; **Joann Gurenlian, RDH, PhD**, Philadelphia, Pennsylvania; **Margaret Walsh, RDH, MS, EdD**, San Francisco, California; **David Singer, DMD, PhD**, Winnipeg, Manitoba; **Michele Darby, RDH, MS**, Norfolk, Virginia; **Magan Kromer, PhD**, San Antonio, Texas; **Denise Bowen, RDH, MS**, Pocatello, Idaho; and **Kathleen Newell, RDH, PhD**, Minneapolis, Minnesota.



Andrew Gillies (Henry Higgins) and Seana McKenna (Eliza Doolittle) in the 1992 Shaw Festival production of *Pygmalion*. (Photograph by David Cooper)

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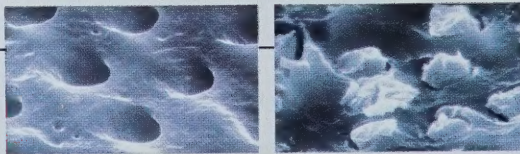
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The Canadian Dental Hygienists Association requires an outstanding dental hygienist to serve as Editorial Director of the Journal. This is a volunteer position.

Responsibilities:

The Editorial Director is directly responsible to the Executive Council and will be charged with overseeing the clinical, scientific and technical content of the Journal. Specific duties include soliciting material for publication, consulting with central office staff, and supervising the manuscript review process. The Editorial Director will be responsible for writing or soliciting appropriate editorials.

Qualifications:

The successful candidate will be a member of CDHA, possess good writing skills, and be able to work well in a collaborative team environment. Candidates should be prepared to commit to a minimum of 10 hours per month to Journal related duties. The Editorial Director may be requested to meet with Central office and Executive Council on a yearly basis. Attendance at the CDHA Professional Conference may be required. On such occasions, travel expenses will be handled according to CDHA reimbursement policies.

Interested candidates are invited to submit a curriculum vitae and a sample editorial appropriate for publication in the CDHA Journal *Probe* to the following address:

CDHA, 1018 Merivale Road, Suite 201, Ottawa, Ont., K1Z 6A5

Nanaimo, B.C.

Our Nanaimo office requires a full-time hygienist immediately. We have an opening in a progressive office with great patients, team spirit and an excellent periodontal program. Please submit résumés to:

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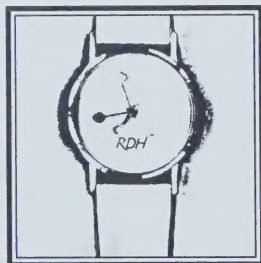
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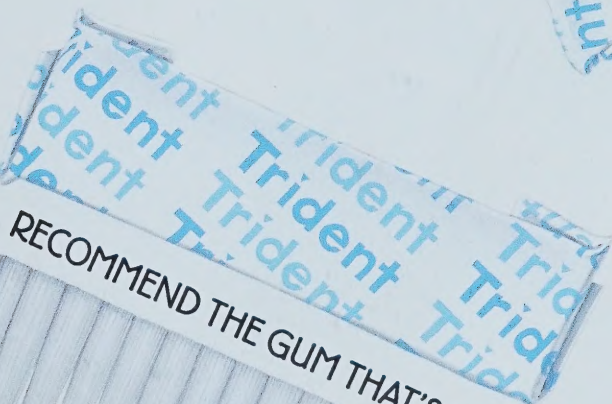
To All CDHA Members

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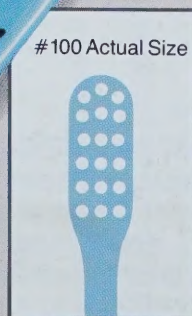
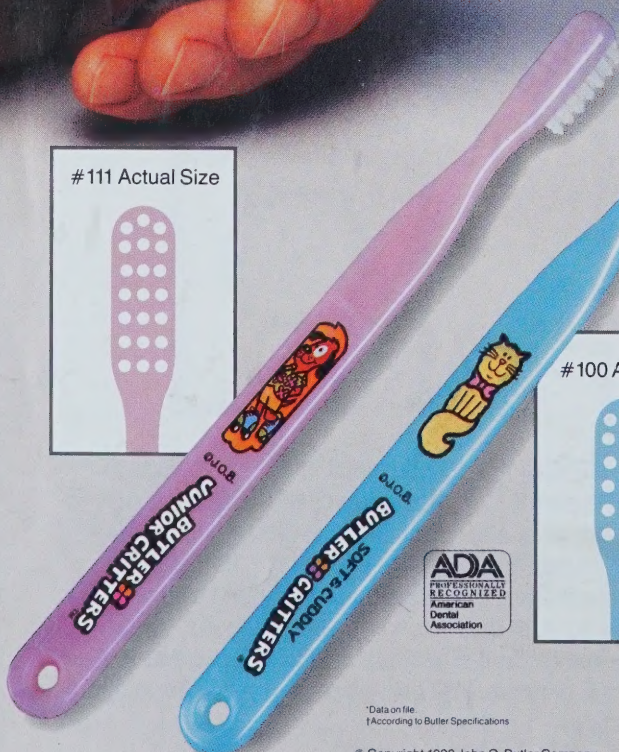
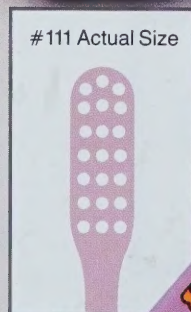
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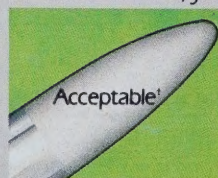
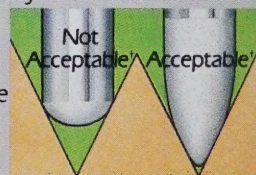
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THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
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PROBE

VOL 27, NO 3

MAY/JUNE 1993 MAI/JUIN

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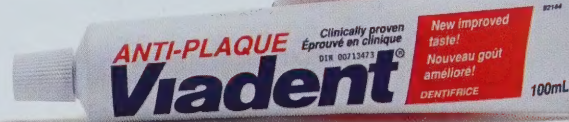
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References:

1. Hanna JJ, Johnson JD, Kuflinec MM. Clinical evaluation of sanguinaria-containing toothpaste and oral rinse. American Journal of Orthodontics and Dentofacial Orthopedics, 1989, Vol. 3: 199-207
2. Harper DS, Mueller LJ, Fine JB, Gordon J, Laster LL. Clinical efficacy of a dentifrice and oral rinse containing sanguinaria extract and zinc chloride during six months of use. J Periodontol, 1990; 61: 352-358



Here we are at the end of my term as President and so much is happening across the country. In British Columbia we now have dental hygienists facilitating the oral health needs of persons with mental handicaps living in the community. Dental hygienists across the country are working diligently on self-regulation. In Ontario, hopefully, The Regulated Health Profession Act will be proclaimed in the Fall of 1993 giving Ontario dental hygienists self-regulation. British Columbia is awaiting word. Alberta and Quebec are already self-regulated.

Personally, one of the greatest moments of the last year was in February when two Canadian dental hygiene students drove from Buffalo to Mississauga (two hours) to attend the Halton Peel dental hygiene meeting. The two students will be practising in the Toronto area next year and they wanted to become involved in a local association. They approached me to talk about our Association, and to ask what could they do and when. They couldn't understand why every dental hygienist isn't a member of the professional association and neither can I.

During the last year, I have had the opportunity of facilitating three Quality Assurance workshops. What an experience to work on this level with other dental hygienists who are committed to quality care and who are searching for ways to improve their skills and the communication within their office. All of us leave these workshops with our batteries recharged and an action plan for making changes including the facilitator.

It has been a pleasure and a privilege for me to meet and work with other health professionals across Canada. Every province has its own issue to handle and The Canadian Dental Hygienists Association is there for resources — body, spirit and dollars.

We have made changes in our National Journal of which I am very proud. We have started to produce the Journal bi-monthly, and members are sending along favourable



LORRAINE BOOMHOUR, RDH

comments. Please let us know what **you** think. During the year I had the opportunity to visit many colleagues to discuss the future of dental hygiene and our association. The profession of dental hygiene is changing whether we like it or not. CDHA believes we must play an active role in that change or it will happen to us rather than with us. There will always be a group who cannot see, or understand the true role of dental hygiene. Across Canada, as legislation changes, I pray that we will have the opportunity to expand our role and contribute to the overall health of the public. We must accomplish our mission statement of contributing to the health of the public. As I have said over and over, we must hold hands and go together. We must support and help each other. Criticizing does not move us forward unless it is very constructive. I would suggest that all of us, being supportive in whatever way we can, will move our profession forward. Never lose sight of the dream. No dreamer is ever too small and no dream is ever too big.

As I think about the CDHA Management of Dental Hygiene Care Statement, I look at my employment situation. I work in a truly collaborative practice with the focus on the

client. I do look forward to the time when dental hygienists will be able to continue dental hygiene care for their patients who are confined to their homes. When that happens, I will be satisfied that we (my dental office) are providing the kind of dental care that the public wishes.

CDHA is very fortunate to have a staff under the leadership of Carol Matheson Worobey, executive director who are very hardworking and dedicated to making the tasks of the executive and board of directors that much easier.

Thank you to the group at 1018 Merivale Road, Ottawa from the bottom of my heart.

I am very proud to be a part of CDHA and extremely grateful for the opportunities I have had since becoming a member many years ago. I'm certainly not finished yet and look forward to many more years of supporting those dental hygienists who choose to lead our profession.

Thank you for your support and have a wonderful summer. 



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COVER

Terry Mitchell, of Dartmouth, Nova Scotia, teaches at Dalhousie University and is in private practice in Halifax. Ms. Mitchell obtained her BSc in Biology in 1974 and later received a Diploma in Dental Hygiene (1978). In 1989 she earned a Masters of Education. Ms. Mitchell was CDHA President for 1991-92.

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Canadian Dental Hygienists Association Community Health Audiovisual Aid Library Acquisitions



HIV Infection

Following the 2nd workshop on AIDS and HIV Infection organized by the Faculty of Dentistry, University of Western Ontario in October 1990, the Federal Centre for AIDS and HIV Infection filmed videos of the speakers in Toronto. The content reflects their workshop papers. (one each, available in either English or French)

I Oral problems of Patients with AIDS and HIV Infection (48.06 min) features Dr. Norbert Gilmore of McGill; and Mr. Rick Hill, a patient. The major impact HIV has had, and will have, on dentistry is discussed.

II The Global Occurrence of AIDS (23.29 min) Professor Jens Pindborg, Royal Dental College, Copenhagen, discourses on the present trends indicating a dramatic increase in the heterosexual distribution of acquired immunodeficiency syndrome in Africa, Thailand, and some Latin American countries. According to WHO predictions, some 4 million infants will have been born to HIV-infected women by the year 2000. The dental profession faces a great challenge as many HIV-infected patients will have oral manifestations.

III HIV-associated Periodontal Disease (40.29 min) Dr. James R. Winkler, University of California, discusses the severe forms of periodontal diseases associated with defects in the immune system, focusing on their distinguishing features, microbiology and treatment.

Children

These four videos were produced by the American Dental Association.

I Toothbrushing with Charlie Brown (5 min) Charlie Brown teaches Linus and Snoopy how to brush. Lucy knows it all, except that Snoopy used her brush. Suitable for: primary-grade children to adults. (two available)

II It's Dental Flossophy, Charlie Brown (5 min) Lucy teaches Charlie Brown and Snoopy how to floss, while Woodstock has his own use for floss — building a nest. Suitable for: primary-grade to adults. (two available)

III The Barnyard Snacker (5 min) Detective Tooth Chicken teaches Hungry Hog and other barnyard animals a lesson on nutrition.

Suitable for Primary to sixth-grade children. (two available)

IV The Haunted Mouth (13 min) Invisible B. Plaque (the voice of Caesar Romero) hauntingly draws the viewer through the dental health message. Suitable for sixth-graders to adults. (two available)

The National Institute of Dental Research in conjunction with the U.S. Department of Health and Human Services produced the following two videos in 1984. Both are now available through the CDHA's AVA Library:

I Fantastic Fluoride (8 min) Designed for grade school students, this video is narrated by a teenage youth who describes to her seven-year-old companion, Joey, the process of tooth decay and the most effective methods of preventing this disease.

II Fluoride: The Magnificent Mineral (13 min) This video educates about fluoride, how it works and why it is important, and is designed for adults and adolescents. The dynamic process of demineralization and remineralization (replacement of the lost minerals in the tooth surface with fluoride) is depicted through animation.

Canadian Dental Hygienists Association Community Health Audiovisual Aid Library Order Form

Notes to the Borrower:

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- 5) Should you have any suggestions for library acquisition or you would like to place your order by phone please contact: Donna Awrey, 1018 Merivale Rd. Suite #201, Ottawa, Ontario, K1Z 6A5 or by phone at 1-800-267-5235.

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In The Looking Glass

I'm sure you've all heard stories of the 30's, those times in the Great Depression when our parents and grandparents suffered through one of our country's most difficult economic eras. The happy ending to this story is that times got better and they went on to enjoy the relative boom of the 50's and 60's; in fact, that's when most of us came along. They relished these prosperous years and provided us with the serendipities of economic growth; freedom from early forced labour, a good education, and a chance to explore and enjoy our youth. For the most part, we lead rather charmed lives, never having faced the ravages of war or hunger, never saving food stamps or even making do without our dishwashers. What irony that with all their good intentions our generation now faces a future that begins to mirror our parents' past. In the looking glass our challenges reflect as opposing times; prosperity in our youth and disparity in our later years.

Our well-deserving parents have, for the most part, been able to go on to comfortable retirements. The Canada Pension Plan is in force, the Veteran's Retirement Fund, and always, the stable savings many of them became so adept at stashing away; a penny saved is a penny earned. But what of our children's future and our retirement?

Our excesses are no longer able to be financed by our dwindling productivity. The developed countries of this world have thrived on intemperance and overindulgence and we now face the reality of curbing our lifestyles. Although many of our contemporaries bemoan the lean years to come I believe it's all a matter of perception; we're about to partake in one of the most progressive times in our lives and possibly of this



MARILYN GOULDING, RDH, BSC

century. Our parents left us one precious legacy in our good educations and driven mindsets. Our generation is 'Empowered'. We are about to take hold of this looking glass to shatter its doomed reflection. We'll use this empowerment, as one of our pop culture heroes so aptly puts it, to "Heal the World".

Downsizing, re-structuring, re-evaluation, re-focusing, de-layering, prioritizing; this is some of the new jargon that peppers our conversations and newscasts. These need not be negative terms. They are tempered terms that beseech a positive approach to necessary tasks. It is better to take control of the unavoidable changes that face our world than to have those changes take control of us. Our families, our communities, our countries and ultimately our world will become more efficient; ecologically, economically and politically because of these changes.

The health care system in Canada is overdue for application of the jargon above. In our parents' day the system was physician/dentist driven and care was delivered almost universally in hospital/office-based settings. I'd warrant that some of you even remember the famed "physician house call"! Care was often unmanaged with a specialist solicited here and there as needed. Little, if any, interdisciplinary communication took place and the costs of multitudes of tests escalated under this trial and error approach. Medical, dental and surgical interventions were undertaken with minimal regard to expected outcomes. Comprehension and understanding of the treatment by the patient were not a consideration nor were the social or emotional impact of the illness. Prevention was not addressed and health promotion was not yet conceived.

The World Health Organization has taken the lead in shifting its definition of health from the absence of illness to a functional outcome based on a "holistic understanding of well-being and an individual's interaction with the environment." Canada has followed suit by instituting a sweeping nationwide review of each province's health care system and we are gearing up for major health care reform based on a client-driven model delivered in a community-based setting. We anticipate a future system that will foster interdisciplinary interaction, provide well-monitored care with treatment choices clearly presented to clients informed of the clinical outcomes and able to make those critical choices. We will be working within a responsible and accountable health care system following our clients into the community and promoting their continued health and well-being.

Sounds great! How do we get there? Read what Thomas W. Langfitt, MD, President of the Pew Charitable Trusts, has to say, "The 'Pew Health Professions Commission' believes that change must begin with a new vision of what health professionals ought to be doing that they are not doing today. . . . The Pew Health Professions Commission was inspired by the belief that the education and training of health professionals is out of step with the evolving health needs of the people. . . . Simultaneous improvements in the education and training of health professionals are required. . . . Conversion to the new model recommended by the Commission is the greatest single challenge faced by the health professional schools. . . . I believe health care reform should proceed along two parallel paths; reorganization and refinancing of the system to contain costs and provide access for all citizens; and reform of education and training to produce more effective and responsive professionals. One without the other is not enough."

The Pew Health Professions Commission was formed of twenty-seven individuals, interdisciplinary in their fields of expertise and drawn from both the public and private sectors, to consider the competencies that will be needed by the health practitioners of the future. The competencies involve not only expanded skills but new attitudes. The report, "Healthy America; Practitioners for 2005", is meant to provide a guideline for educators to ensure that today's students, the health professionals of the twenty-first century, are able to thrive as practitioners in tomorrow's radically different and ever-changing new health care environment. It is charging the schools to play a more proactive role in shaping the nation's strategy for change.

The leadership challenges relegated to our schools include:

- i) interaction of the academic disciplines in a program of education, research and client care;
- ii) development of an institution-wide mission statement aligned with the interests and skills of the professional departments as well as the needs of the communities it serves;
- iii) articulation of the models of specialized technically trained experts to break the boundaries of separate disciplines and professions; new ways of organizing people and knowledge;
- iv) reallocation of funds to meet the declining resource realities of the present yet focused to meet the emerging problems of the health care system and support new programs designed to provide the skills necessary to address these problems;
- v) to work with accreditation and licensing bodies to encourage rather than impede change;
- vi) to develop outcome evaluations and the critique of the effect the educational program has on those outcomes; the impact of faculty's contributions towards the goals of the program and the activities of its graduates in practice;
- vii) the development of reward structures to secure interest in educational reform; rather than reward only for performance in research;
- viii) fostering a faculty commitment to the institutional mission rather than departmental aims; to develop a greater sense of shared institutional purpose;
- ix) support for integrated portions of different educational programs to meet the changing health care needs of the public; and
- x) to disassemble the "bastions of power" which have been created in our professional schools and move them towards the central mission of the institution.

The competencies for the health care pro-

fessional for the year 2005 and beyond are seen as:

- care for the community's health
- expand access to effective care
- provide contemporary clinical care
- emphasize primary care
- participate in coordinated care
- ensure cost-effective and appropriate care
- practice prevention
- involve clients and families in decision-making
- promote healthy lifestyles
- assess and use technology appropriately
- improve the health care system
- manage information
- understand the role of the physical environment
- provide counseling on ethical issues
- accommodate expanded accountability
- participate in a racially and culturally diverse society
- continue to learn

The document, "Healthy America; Practitioners for 2005", also provides information on strategies for this change, health care trends for the year 2005 and beyond, an agenda for action, demography, economics, cultural values in health care, governance in health care, access to health care, health care delivery systems, and quality of health care. The CDHA Board of Directors has identified this document as a key resource in planning and leading dental hygiene into the twenty-first century.

Every health care professional interacting in our educational or health care system in this country should read this document. It is an agent for change and unless we are open to change and, ourselves, become agents for change, we will not be able to impact on change. Rather, change will impact on us. 

If you would like a copy of the Pew report, please contact:

Pew Health Profession Commission
University of California
San Francisco
Box 1242
San Francisco, CA
94143-1242
(415) 476-8181



Location of gene causing familial ALS found

A team of scientists, led by the Amyotrophic Lateral Sclerosis Society of Canada funded researchers at McGill University, Montreal, have successfully identified a gene, that when defective, causes most cases of familial (inherited) amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease. The findings are reported in the March 4, 1993 issue of the scientific journal *Nature*.

Drs. Denise Figlewicz, Guy Rouleau, Jun Goto, and Aldis Krizus, of the Center for Research in Neuroscience at McGill University and the Montreal General Hospital, together with a number of American scientists notably Dr. Robert Brown Jr., from the Neurology Department of the Massachusetts General Hospital in Boston, undertook the study with medical research grants from ALS Societies in Canada and the United States to identify the gene(s) involved in familial ALS (FALS). Two years ago these same teams in collaboration with Dr. Teepu Siddique of Duke University established that a gene responsible for FALS mapped the human chromosome 21q.

ALS is a devastating neuromuscular disease caused by the degeneration of large motor neurons of the brain and spinal cord. It results in generalized and progressive weakness and wasting of skeletal muscles, paralysis and death, generally within five years. Although their muscles atrophy, many patients have likened ALS to being "buried alive" since their mind remains alert and lucid through the course of the disease. Currently there is no cure for ALS or known treatment to reverse or halt its course.

"Because this fatal disease disables its victims so quickly and their lifespan is generally so short, they are not seen and heard as are people with many other illnesses," said Mr. Reg Watts, President of the ALS Society of Canada. "The ALS Society of Canada is working to raise money for research through a variety of events across Canada, and increase public awareness of the disease. We are also looking for volunteers to assist us in those efforts, particularly in the Society's annual Cornflower Days during June which is ALS Awareness Month," he concluded.

CDHA/ADHA Liaison Meeting

CDHA was host for the annual USA/Canada liaison meeting held March 18 and 19, in Ottawa. The event provided both associations an opportunity to share plans, projects and finalize details for the North American Research Conference in October. Discussion included accreditation, restructuring Code of Ethics, education, practice standards, changing health care delivery, access to care, research, IFDH, national dental hygiene week, and increased collaboration among colleagues.



CDHA/ADHA Liaison Participants: L-R Terry Mitchell (CDHA Past-President), Dale Scanlan (CDHA/IFDH Rep.), Lorraine Boomhour (CDHA President), Ellen Brownstone (CDHA/IFDH Rep.), Sarah Turnbull (ADHA President-Elect), Marge Reveal (ADHA/IFDH Rep.), Debra Bailey-McFall (ADHA President), Fran Richardson-Cotton (CDHA President-Elect)

Canadian Physiotherapy Association's Position Statement on Canada's Health Care System

Canadians place a high value on, and are proud of, their health care system.

The health needs of individuals and society are evolving and demand a broad range of community — and institutionally-based services. The model for the Canadian health system should be an integrated continuum of care, providing coordinated access to a range of types and levels of services. Administrative and financial arrangements should be designed accordingly.

The Canadian Physiotherapy Association (CPA), established in 1920, represents close to 8,000 physiotherapists across the country. Its mission is to provide leadership and direction to

the profession, foster excellence in practice, education and research, and promote high standards of health in Canada. CPA has branches in all provinces and councils in the territories.

CPA is committed to preserving the right of reasonable access to high-quality health care regardless of ability to pay. CPA is also committed to maintaining national health care standards (portability, accessibility, comprehensiveness, universality and public administration), developing health goals and ensuring that all Canadians receive the most appropriate care when required.

CPA supports the goal of maintaining the national integrity of the health care system.

CPA views stability in funding as essential to effective health care planning and believes that unplanned and unilateral federal reductions will compromise national health care standards and quality of care.

CPA believes that the principles of the *Canada Health Act* must be maintained in a renewed health care system. The system must provide for public participation, make provision for patients to obtain improved access to health care through additional recognized accredited professionals (such as physiotherapists), and appropriate use of resources. Collaboration among health care professionals, institutions and governments must be enhanced. To do so, there must be a shared vision and a willingness to look at new ways of doing things.

CPA challenges the federal and provincial governments to work with each other and organizations such as CPA to guarantee that medicare and its national principles are protected.

June 1992.

The California Project

Introduction to HMPP #139 Reports

In 1987, the American Dental Hygienists' Association, California State University-Northridge, and others helped fund an experimental project designed to evaluate expanded roles for the registered dental hygienist (RDH). The California Office of Statewide Health Planning and Development approved this project to benefit patients of dental hygienists who work without the general supervision of a dentist. The Dental Hygiene Independent Practice Prototype — Health Manpower Pilot Project (HMPP #39), operated at nine sites (including institutions, offices, and patients' homes) in California between January 1987 and December 1989.

RDH's in the HMPP #39 project would be considered "successful" by California state leaders if they could serve a diverse population, provide quality care, and encourage their patients to visit a licensed dentist for additional oral health care. RDH's professional services typically included prophylaxes, fluoride treatments, clinical evaluations, and other preventive oral health activities. Licensed California dentists reviewed and approved practice plans before sites were opened in January 1987. RDHs were required to inform patients of the experimental nature of HMPP #139. RDHs involved in the project emphasized access, safety and continuity of care.

Researchers James R. Freed, DDS, MPH, and Dorothy Perry, RDH, PhD, evaluated the HMPP #139 project. Freed is a dentist at the University of California-Los Angeles, and Perry is an assistant professor at the University of California-San Francisco, School of Dentistry. They documented their results in Access, Utilization and Quality of Independent Dental Hygiene Practices. Freed and Perry reviewed a random sample of 225 patient records at dental hygiene sites and 122 records from dental practices to compare areas such as access, safety, and continuity of care. Freed and Perry also asked patients in follow-up surveys if they were satisfied with the dental hygiene care they received.

The HMPP #139 project was initially investigated by John E. Kushman, PhD, then as Associate Professor in the Department of Agricultural Economics at the University of California-Davis. Kushman's report, California Health Manpower Pilot Project 139: Independent Practice of Dental Hygienists, summarizes 36 months of data on dental hygiene patient visits at the nine sites. Kushman evaluates the RDH's achievements while serving their communities as dental hygiene practitioners. RDHs set goals for their practices: financial success, practice variety, and professional and personal growth.



Reaching Out to California's Underserved — A Look at HMPP 139*

Marilyn Blackmun, RDH, BS, drives an hour each way to provide oral health care to a Los Angeles area woman who is home-bound with cerebral palsy. Toni Ebner, RDH, BS; Teresa Eslinger, RDH, BS; and Nikki Smith RDH, BS, provide oral health care to low-income residents of a small northern California town. Judy Boothby, RDH, provides oral health care to residents of skilled nursing facilities in Fair Oaks, California. These dental hygienists are able to work in non-traditional settings, where they provide oral health care to underserved populations, because they are part of a health manpower pilot project — HMPP #139 — which allows them to practise unsupervised.

"In the 1970s," according to Toby Segal, RDH, "dental hygienists in California were experiencing a work crunch." In response to this situation, Segal says that the Southern California Dental Hygienists' Association, (SCDHA) held a futures conference at which dental hygienists and other health care experts discussed the future of the dental hygiene profession.

As a result of this conference, Segal became chair of a committee charged with finding a

plan for alternative settings which would allow greater public access to quality oral hygiene care. In 1979, the committee presented a proposal to the SCDHA that a health manpower pilot project (HMPP) be developed and presented to the California Office of Statewide Health Planning and Development (OSHPD).

In 1981, the grant proposal, written by Jerome Seliger, PhD, of the university's Health Sciences Department, was accepted by OSHPD and named HMPP #139. Between 1981 and 1986 funding was sought. Finally, with contributions, the project was ready to begin and applications were sought for dental hygienist participants.

The Applicants

Applicants were required to have a minimum of four years practice experience, CPR training, current licensure, and evidence of ongoing continuing education.

Marilyn Blackmun, RDH, BS, for example, had over 23 years of experience, including six years in a periodontics practice, when she applied for the program.

Judy Boothby, RDH, had graduate training in dental care of the disabled and elderly at the University of Washington.

Laurelyn Borst, RDH, BS, MA, had been practising for over twenty years and had a master's degree in psychology.

Elizabeth Jones, RDH, and Nancy Chesler, RDH, had started and managed their own businesses in addition to practising dental hygiene.

Experience and education was something that all the applicants brought to the program. In addition, they all brought with them a sense of frustration and a feeling that their education and experience were being wasted.

The Education Component

According to Segal, the education component of the HMPP program involved almost 500 hours of course-work and clinical residence. Several of the participants drove considerable distances from their homes each week-end to attend classes at Northridge.

The curriculum for both classes consisted of accounting, hiring/firing, practice management, management psychology, and health care management, as well as clinical dental hygiene refresher courses, explains Segal.

The Practices

The practices the participants set up took many forms.

Marilyn Blackmun and Charlotte Burruso, for example, had a mobile practice which they marketed to skilled nursing facilities and home-bound patients. They provided oral health care to patients as well as oral hygiene instruction to both patients and staff.

Other participants who choose to set up similar mobile practices also saw an increasing awareness of oral health. Ginger Koshay commented that her home-bound patients now asked about their oral health status.

Participants also remarked that their patients would not be receiving any oral health care if it weren't for them. "I don't know where these people would go for care," said Judy Boothby.

Each patient who comes to an HMPP practice for care is required to sign a consent form explaining the services they can receive. Moreover, all patients needing restorative care are referred to appropriate dentists. Medical history, infection control, and radiation safety protocol are meticulously followed in each practice.

In addition, experienced dental practice evaluators visit each practice on a regular basis as required by OSHPD. This not only ensures quality control, but it is part of the data gathering essential to any research project.

Evaluation and Data Collection

Max Schoen, DDS, DPH, and Dick Willis, DDS, MPH, are two of the evaluators. Both were selected on the basis of their training and years of experience in dental practice evaluation. They have performed quality-of-care



assessments for the State of California. Both have also had extensive experience in the area of public health.

Schoen says the evaluations take "about half a day." He looks at record-keeping systems, emergency procedures, recall and appointment systems, as well as infection control and radiation safety protocol. He then pulls patient charts to determine whether there is appropriate documentation on medical history and baseline oral examinations. He checks for appropriateness of the hygienist's impression of findings, treatment plan, and follow through. He determines whether patients are being given appropriate referrals.

He later talks with and examines patients in the office to verify notations on their charts. Finally, he discusses any significant findings

with the hygienist and files a report with OSHPD.

According to Schoen, the HMPP hygienists are "being supervised better than hygienists in many dental offices."

Freed comments "These hygienists are seeing home-bound patients, the medically compromised, and the elderly. We're trying to look at this to see if it poses a threat to the public's health" He adds that researchers will also look at "the issue of making care more accessible", a well as "what sort of practice-related courses should be incorporated into regular dental hygiene education programs."

* From an article written by Linda J. King which appeared in the January 1990 *Access*, and reprinted with kind permission of the American Dental Hygienists' Association.

“Is it ethical to have an unwritten office policy to take X-rays every recall?”

**FIND OUT AT CDHA'S 5TH NATIONAL CONFERENCE —
SASKATOON, SASKATCHEWAN, JUNE 17-19, 1994.**

Osseointegrated Implants

A Part of Our Future Here and Now

By:
Marie A. Lochhead, RDH, ASC

Introduction

Osseointegrated implants: something to think about in the future for maintenance needs? No, the future is here and now. With a public conscious of dental advancements more clients are asking about titanium implants. As an intricate part of the dental team and clients' primary oral hygiene consultants, dental hygienists need to be cognitive of the changing maintenance needs of clients.

For many clients osseointegrated implants finally offer an alternative means from conventional treatment. Clients can have a prosthesis that replaces full or partial edentulism, including a single tooth. Implants can offer tooth (teeth) replacement without involving the adjacent natural teeth. Desirability of implants depends on both the clients' physical and psychological state.

Implants

Once the implant is placed into the bone and a healing cap is placed on top, the original tissue is repositioned over the surgical site and sutured. After a healing period of 4-6 months osseointegration is deter-



MARIE A. LOCHHEAD, RDH, ASC

mined. Osseointegration can be defined as a direct structural and functional connection between ordered, living bone and the surface of a load-carrying implant.^{1,2} The area is then flapped back for the healing cap to be removed and an abutment to be placed. The client is now ready for the prosthetic phase to be designed on the implant(s). The total estimated time, from original surgery to loaded implant, is between 6-12 months.

Plaque and Calculus

Plaque forms on titanium implants. The gingival tissue surrounding the implant, (the peri-implant tissue), can pocket similar to periodontally affected teeth. The supra and subgingival microflora associated with titanium implants appears to be similar to natural

teeth. The need for an effective peri-implant maintenance program is supported by these findings.²

Debridement or scaling of the titanium surfaces with metal instruments may cause surface scratches, cuts or gouges that potentially increases plaque retention. Using dissimilar metal instruments on pure titanium implants, may contaminate the oxide layer. The oxide layer on titanium implants is the surface that separates the metal ions from the epithelial tissue and osseous bone. This contamination that alters the oxide layer leads to increase rate of surface corrosion resistance and biocompatibility of titanium. Reattachment of the biological seal, which can be disrupted during a maintenance procedure, could be affected by an increase in plaque retention by the alteration of the oxide layer on the titanium implant surface.^{3,4,5}

Scalers

Studies show that titanium alloy curettes and stainless steel curettes cause gouging and roughening of the pure titanium surface. Greater plaque accumulation can occur when surface scratches are present and affect the relationship of the junctional epithelium. Therefore the choice of scalers are plastic ones.¹ There are a variety of commercially available plastic instruments. (Fig. 1). A clinician may choose from an all-plastic instrument or one with a metal handle with disposable, changeable tips. One should check with the manufacturers' specifica-

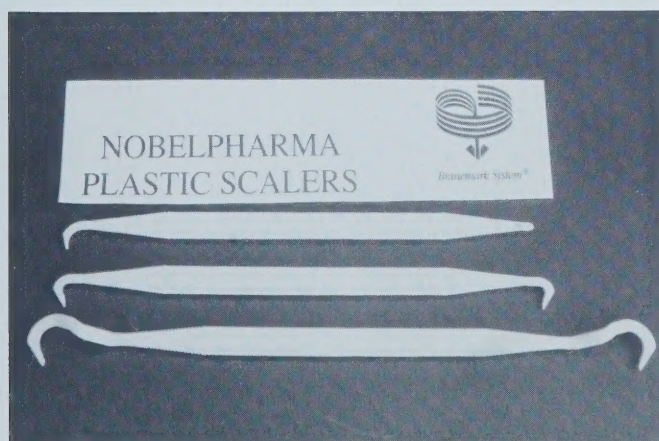


Fig. 1: There are a variety of commercially-available plastic instruments. The above shows one type.

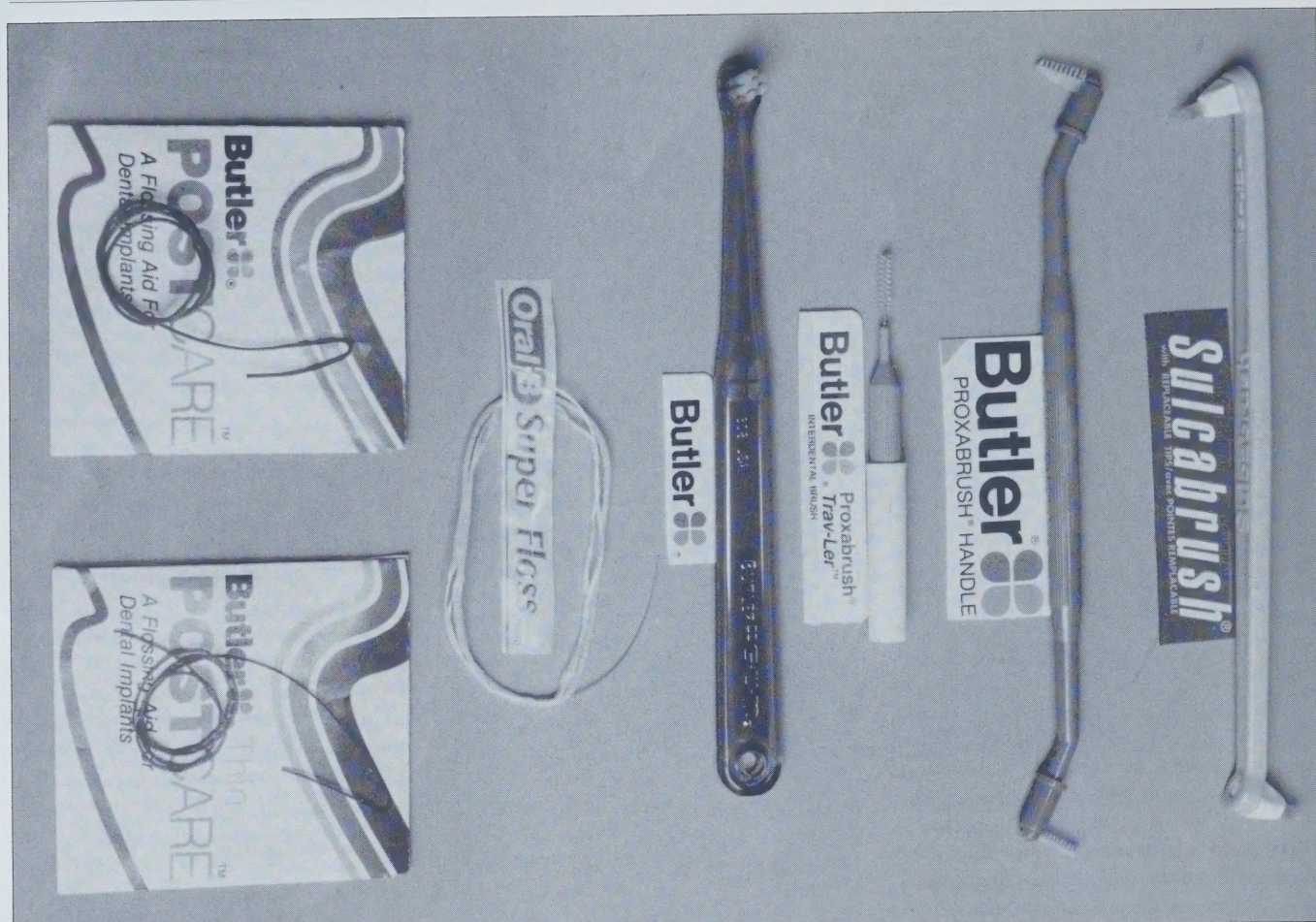


Fig. 2a: A variety of brushes, adjuncts, and flosses used in the maintenance of osseointegrated titanium implants.

tions regarding the amount of time the blades can be utilized and sterilized. The clinician should avoid using heavy pressure while instrumenting with plastic curettes, so as not to disturb the epithelium attachment. The supragingival layers of calculus formed around the titanium implant are not normally difficult to remove, therefore, a light even motion is preferred at the beginning and end of each stroke.

***"As an intricate part of the dental team
... dental hygienists need to be
cognitive of the changing maintenance
needs of clients."***

Ultrasonic scalers (Cavitron, Dentsply International Inc.), sonic scalers (Titan-S, Syntex Dental Products), and air powered abrasive polishing (Prophy-Jet, Dentsply International Inc.) have also been shown to scratch, groove and pit the titanium surface. Rubber cup polishing with Nupro prophylaxis paste (Johnson & Johnson) or the use of an Interplak™, Rotodent™, or chlorhexidine gluconate rinse have shown slight or no change to the implant surface.⁴

Probing

Probing around abutments is debated especially if the gingival tissue is healthy and firm. Probing may cause a rupture in the biological seal

between implants and tissue. This could create a pathway for infection.² If probing is indicated the use of a plastic probe is preferred.

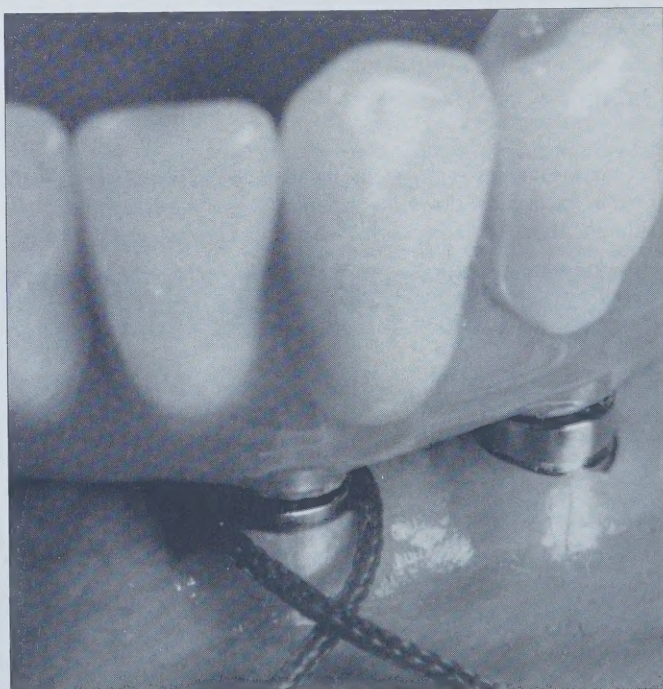


Fig. 2b: Post Care™ produces excellent results for plaque control around the fixtures and abutment cylinders as well as the cervical aspect of the prosthesis, as demonstrated on a model.

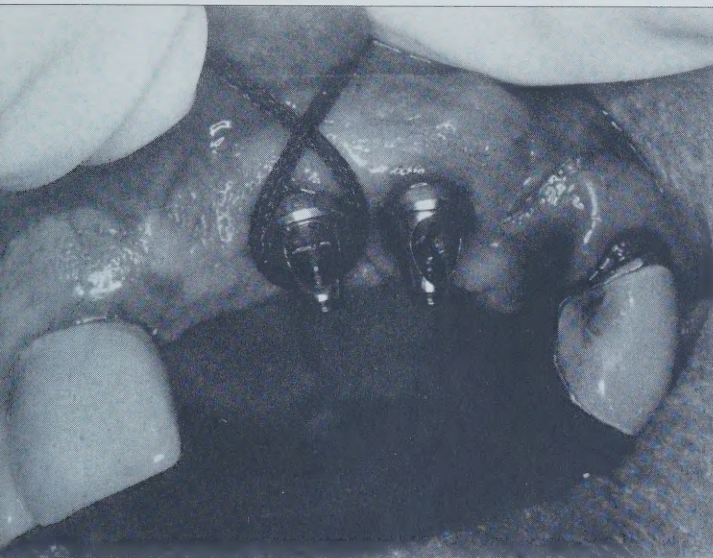


Fig. 2c: Post Care™ around a client's maxillary abutment cylinders. The prosthetic portion has been removed to allow for an increased visual field.

Radiographs

Radiographs are to be taken at 1, 3, and 7 month intervals after implant placement as recommended by Brånemark Systems (Nobelpharma, Sweden). Radiograph check the osseous bone height, condition and fit of the abutment cylinder of each implant. The parallel technique is the best method to achieving good radiographic results.² After one year the implant is considered to have a predictable prognosis. At this point the implant is considered to be at a stable state in which serious complications rarely arise.²

Floss

A variety of floss can be used on implants with or without a threader. A hygienist can choose from conventional floss, precut length floss with threader and fuzzy filament (Super floss, Oral-B) or Post Care braid (John O. Butler Co.) The Post Care™ is specifically designed as "implant floss". It has produced excellent results for plaque control

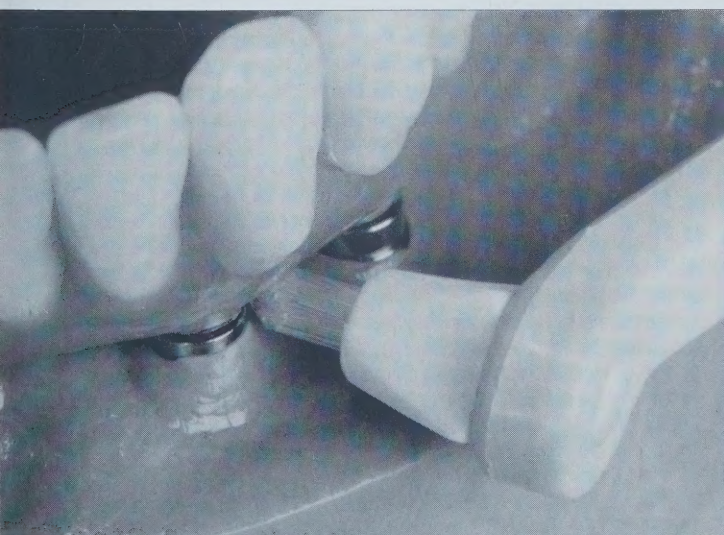


Fig. 3a: A Sulcabrush™ is designed to clean facial and palatal/lingual areas with ease as shown on a model.



Fig. 3b: End tufted soft polished bristled brush is recommended for all exposed portions of fixtures and abutments as shown here on a client.

around the fixtures and abutment cylinders as well as the cervical aspect of the prosthesis. One end of the Post Care™ is bent to allow the client to thread the nylon braid around the fixtures and abutment with ease. Once the braid is in place, the right braid is crossed over to the left side, and the left, crossed over to the right side. A gentle back and forth motion occurs when the braid is pulled side to side gently. The reusable braid is then rinsed and allowed to dry. (Fig. 2) The floss

"Once the prosthesis insertion is completed a hygiene instruction appointment is recommended within one week. Clients should be familiarized with various homecare techniques as per individual needs."

or Post Care™ may also be dipped in an anti-microbial solution of .12% chlorhexidine gluconate to help maintain or reduce peri-implant tissue inflammation.

Brushes and Adjuncts

For general debridement a soft bristled toothbrush can be used on all surfaces. An end tufted soft polished bristled brush is recommended for all exposed portions of the fixtures and abutments, as well as a Sulca brush (Sulcabrush, Inc.) A Sulcabrush™ (Fig. 3) is designed to clean facial and palatal/lingual areas with ease. Interdental brushes with

nylon coated braided wire can be used to clean under fixtures or sides of abutments, however, care should be given that the nylon does not wear away. The nylon coating protects the braided wire from scratching the fixture. These brushes are also available in a pocket size for travel. Handles of the above mentioned brushes can be easily bent at the neck to allow for better access by warming the handle under warm water for a short period of time. Pontic areas may also be cleaned with strips of gauze to debride and continually polish the cervical aspect of the prosthesis. In areas where space is limited, soft nylon mesh can be used.

Anti-microbial Agents

Anti-microbial solutions are also beneficial in maintaining peri-implant tissue. The client can either rinse with the solution such as chlorhexidine gluconate 0.12% rinse or apply the rinse in two different modes. The first is to apply the rinse using cotton applicators which specific site(s) to be reached. The second mode is to dip the floss/cord into solution. In case of a physical handicap or poor access which can prevent proper cleaning of the abutment, the use of long term anti-microbial rinses may be indicated. It should be noted that the use of these rinses should be closely monitored in relation to irritation that may be caused and inflammation of the peri-implant tissue.^{1,2}

Recall Intervals

Once the prosthesis insertion is completed a hygiene instruction appointment is recommended within one week. Clients should be familiarized with various homecare techniques as per individual needs. A baseline status of the client should also be done evaluating the condition of peri-implant tissue, mobility, radiographs of bone levels and occlusal adjustments. The client should then return in 3-4 weeks to reassess oral hygiene. Deposits should be checked for presence. The possible need for the client to use disclosing tablets for home use can also be determined. Recall visits are recommended every 3-4 months. Again the peri-implant tissues, mobility, deposits formation, signs or symptoms of discomfort or infections, status of superstructure and health of clients should be evaluated.^{2,4,5}

Conclusion

More than ever it is an exciting time to be an integral part of the dental team. We, as primary oral hygiene consultants, need to continually stay well informed: this includes the maintenance of implant clients. We need to take on the challenge of these special clients. We need to have both knowledge and tools to do so.

Take the challenge and gain the knowledge — today!

Acknowledgements

The author would like to extend thanks to Dr. Marlene Mader, D.D.S., Cert. Perio. Dr. Karl Gravitis, B.Sc., D.D.S., M.R.C.D.(c), William & Marie Hermann, Denis Lochhead, Stephen Wartman and Michael Harvey for their support, providing material, and time for making this clinical article possible.

References

1. Fox S.C., Moriarty J.D., Kusy R.P. The Effects of Sealing a Titanium Implant Surface With Metal and Plastic Instruments: An in Vitro Study. **J of Periodontol** 61: 485-490, 1990
2. Brånemark System: Clinical Guidelines for Hygiene Maintenance of Patients Treated with Brånemark System. Nobelpharma: Nobel Industries Sweden. **USP** 146: 1-7, July 1991
3. Lekholm U., Adell R., Lindhe J., et al: Marginal Tissue Reactions at Osseointegrated Titanium Fixtures. **Int J. Oral Maxillofac. Surg.** 15:53-61, 1986
4. Neal D., Evans G., Meffert R. Effects of Various Prophylactic Treatments on Titanium, Sapphire and Hydroxapatite-Coated Implants. An SEM Study International. **J of Perio & Rest Dent** Vol. 9 No. 4:301-311, 1989
5. Balshi T. Hygiene Maintenance Procedures for Patients Treated with the Tissue Integrated Prosthesis (Osseointegration) **Quintessence International** 17:95-102, 1986
6. Buser D., Warner K., Karring T. Formation of a Periodontal Ligament Around Titanium Implants. **J of Periodontol** 61:597-601, 1990

Marie Lochhead resides in Fort Erie, Ontario. She received her Associates in Science Degree with Honours in 1981 from Onondaga Community College, Syracuse, New York. She has practiced clinically in both the United States and Canada. Marie has been a clinical periodontal hygienist for the past ten years in private practice.

ANTI-PLAQUE
Viadent®
 Sanguinaria Extract
 Anti-Plaque/Anti-Gingivitis Preparations
 HORNER
 Montreal, Canada

INDICATIONS: Adjunctive treatment for the maintenance of good oral hygiene, control of dental plaque and the reduction and inhibition of gingivitis.

CONTRAINDICATIONS: Other than hypersensitivity to Viadent or one of its components, there are no contraindications to the use of this product.

PRECAUTIONS: It is possible that Viadent Anti-Plaque preparations may interact chemically with other orally applied drugs, although no such drug interactions have been reported to date. Routine swallowing of the product is not recommended.

Staining of dental restorations does not appear to be a problem with Viadent preparations. In laboratory testing with the rinse, only one light-cured composite, Durafil-Kulzer, was slightly yellowed after immersion in the rinse for 24 hours.

Use of Viadent Anti-Plaque preparations is not recommended in pediatric oral health programs due to the alcohol content in the rinse and for the toothpaste, when caries is the principal dental disease and for which a fluoride product is indicated.

The safe use of Viadent Anti-Plaque preparations during human pregnancy and lactation has not been established. As with any drug, use during pregnancy or lactation requires that the expected therapeutic benefit of the drug be considered against the unknown risks to the mother, fetus or neonate.

DOSAGE AND ADMINISTRATION: Viadent Anti-Plaque Oral Rinse: Administer after brushing morning and evening. Rinse twice consecutively using 15 mL per rinse for 15 seconds each time.

Viadent Anti-Plaque Toothpaste: Administer as a ribbon of paste on a toothbrush morning and evening.

SUPPLIED: Viadent Anti-Plaque Oral Rinse: Bottles of 500 mL.
 Viadent Anti-Plaque Toothpaste: Tubes of 50 mL, 100 mL.

CDHA Conference

A North American Research Conference

October 15 - 17, 1993 — Niagara Falls, Ontario

Program Outline

Friday, October 15 Preconference Workshop

Moving The Profession Of Dental Hygiene Towards The Year 2000

Facilitator: Susanne Sunell

See page 95 for details & registration form.

Opening Reception Friday Evening

Guest Speaker: Dr. Roberta Bondar is best known as an astronaut who flew on the Discovery in January 1992. On the mission, she performed experiments in the Spacelab and on the middeck. Dr. Bondar is a neurologist, a clinical and basic science researcher of the nervous system and conducts research into blood flow in the brain during microgravity, lower body negative pressure and various pathological states. Dr. Bondar has received a plethora of special honours over the past two decades, including numerous Honourary Doctorates from universities throughout Canada. She also is the recipient of Chatelaine Magazine's 1993 Woman of the Year Award.

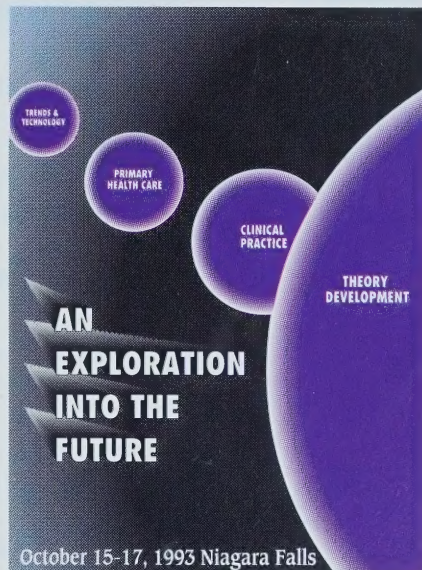
Saturday, October 16

Keynote Speaker: Dr. Jane Fulton will elaborate on the need for research in dental hygiene, and the relationship of research to professionalism. The necessity of integrating theory and practice in dental hygiene will also be discussed.

Presentations: That will appeal to both practitioners and researchers

• **Remaining Current in Practice:** This session will deal with information retrieval practices. What resources do people use to stay current?

• **Using Research in Dental Hygiene Practice:** How do we transfer knowledge from research to the dental hygiene practice? What are the barriers?



• **Submitting Manuscripts to Dental Hygiene Journals:** Joint presentation by CDHA and ADHA on how to prepare manuscripts for submission to their respective journals. A review of the ingredients of a scientific paper and evaluation mechanisms used by both associations in assessing manuscripts for publication. Learn how to transform your expertise into the written word.

• **Understanding the Scientific Literature:** Why must dental hygienists examine the scientific literature and what is the importance of the literature in developing the "art and science" of dental hygiene? This presentation will describe types of scientific literature, and the use of abstracts by dental hygienists.

• **Theory Development Workshop:** A working session designed to consider: theories related to the practice of dental hygiene, the categorization of data to formulate theory, the structure and development of models, how to set up research to test models, and how to validate theory.

• **Testing & Validating Theory Workshop:** Designed to build on Theory Development workshop by examining "Human Needs Theory" or other appropriate theories, and the relationship of theory to dental hygiene practice. How do you test and validate such theory? What is its clinical application?

• **Free Papers**

• **Commercial Exhibits** (all day)

• **Table Clinics and Poster Sessions**

Sunday, October 17

• **Mini-Sessions:** Explanation and examination of current research efforts which will affect the practice of dental hygiene now and in the future. Topics will include the use of lasers, saliva research, the use of computers for assessment and diagnosis, the purposes of microbiological testing, and research on health policy, demographics and economics.

• **Survey Research Workshop:** Survey research methods are frequently used by dental hygiene researchers to assess knowledge, attitudes, skills, beliefs, and practices. This workshop is designed to describe the purpose of survey research as well as offer participants a practical understanding of how to develop and conduct surveys. Means of analyzing survey results will also be discussed.

• **Qualitative Research:** Qualitative research design and methods are best suited to questions that are exploratory in nature or which seek to provide an "in-depth" understanding of detail and experience. This presentation is designed to inform dental hygiene researchers about the usage and strategies of qualitative research.

• **Common Flaws in Research:** A "learn from your mistakes" presentation on common flaws in research relating to methods, writing techniques, literature reviews, problem formulation, sample errors, external validity and statistical analysis.

• **Corporate Panel Discussion:** Representatives of the "corporate world", government / non-profit agencies and the dental hygiene community will discuss the influence of funding sources on current and future research, funding priorities, grantsmanship, and the role of the dental hygienist in oral health research.

Schedule of Events

DAY/DATE

FUNCTIONS

Friday, October 15, 1993

- | | |
|----------------|--|
| All Day | Moving The Profession Of Dental Hygiene Towards The Year 2000
(Workshop — see page 95 for details)
<i>Facilitator:</i> Susanne Sunell |
| Evening | "Women in Science & Research"
<i>Guest Speaker:</i> Dr Roberta Bondar
<i>followed by Wine & Cheese Reception</i> |

Saturday, October 16, 1993

- | | |
|---------------------|---|
| 8:30 - 9:30 | "Health Care Trends"
<i>Keynote Speaker:</i> Dr Jane Fulton |
| 9:00 - 12:00 | Commercial Exhibits |
| 9:30 - 11:30 | Table Clinics & Poster Sessions
Details to be printed in next issue of <i>Probe</i> |
| 9:30 - 12:30 | 1) "Remaining Current in Dental Hygiene Practice"
Sharon Gravois, RDH (USA)
2) "Using Research in Dental Hygiene Practice"
Linda Kraemer, RDH, PhD (USA)
3) Manuscript Preparation
Marilyn Goulding, RDH, BSc (Probe-CAN)
JoAnn Gurenlian, RDH, PhD (Dental Hygiene-USA)
4) "Understanding the Scientific Literature"
Nancy Keselyak, RDH, MA (CAN)
<p style="text-align: center;">— or —</p> 9:30 - 12:30 Theory Development Workshop
Jacqueline Fawcett, PhD (USA)
2:00 - 5:00 Testing & Validating Theory Workshop
Margaret Walsh, RDH, EdD (USA)
Michele Darby, RDH, MS (USA)
2:00 - 5:00 Free Papers
Details to be printed in next issue of <i>Probe</i>
2:00 - 5:00 Commercial Exhibits |

DAY/DATE

FUNCTIONS

Sunday, October 17, 1993

- | | |
|---------------------|---|
| 8:00 - 9:00 | Chlorzoin Therapy
A treatment researched and developed by Jim Sandham, DDS, PhD, of the University of Toronto |
| 8:30 - 10:15 | "Qualitative Research"
Karen Grant, PhD (CAN) |
| 9:00 - 12:00 | Mini Sessions: Research That Will Affect Future Dental Hygiene Practice
<i>Moderator:</i> Janice Pimlott, RDH, MSc
1) Lasers — Patricia Ling, DMD, MSc
2) Saliva Research — Colin Dawes, BDS, PhD
3) Computers in Practice — David Singer, DMD, PhD
4) Micro-Diagnosis — Marilyn Goulding, RDH, BSc
5) Health Policy, Demographics, and Economics — Joanne Clovis, RDH, MSc
9:00 - 12:00 "Survey Research workshop"
Megan Kromer, PhD (USA)
10:15 - 12:00 "Common Flaws in Research"
Denise Bowen, RDH, MS (USA)
1:00 - 3:00 Corporate Panel Discussion
<i>Moderator:</i> Kathleen Newell, RDH, PhD (USA)
<i>Corporate Dental Hygiene Representatives</i>
Teledyne Inc. (Marsha Stein, RDH (CAN))
Proctor & Gamble (Janet Cain-Hamlin, RDH, MS (USA))
<i>Representatives from Government/ Non-Profit Agencies</i>
Canadian Fund for Dental Education
Health & Welfare Canada
National Institute of Dental Research
<i>Dental Hygiene Researchers</i>
Patricia Johnson, RDH, PhD (CAN)
Karen Gross, RDH, MS (USA)
3:00 - 5:00 Plenary: Theory Development Workshops
<i>Moderators:</i> Denise Bowen, RDH, MS (USA)
Laura MacDonald, RDH, MEd (CAN)
Time tba Free Papers
Details to be printed in next issue of <i>Probe</i> |

Travel Arrangements

CDHA has appointed **MKI Travel and Conference Management Inc.** and **Air Canada** as the official Travel Agency and Airline for this event.

The Benefits:

- Special negotiated conference airfares and savings up to 65% off full fares
- A dedicated team of bilingual conference travel experts
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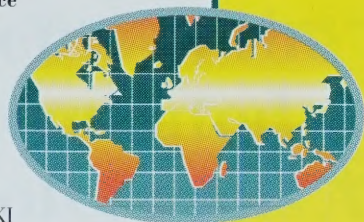
and ask for Pattie or Gerri-Lynn

or non-residents of Canada
may call collect:

(613) 234-1395

Niagara Airbus shuttle service is available from both Toronto and Buffalo airports. Estimated costs:

Buffalo airport to Niagara (return) - approx. \$75 Cndn pp
Toronto airport to Niagara (return) - approx. \$60 Cndn pp



Niagara-on-the-Lake Shaw Festival

SAINT JOAN

SATURDAY EVENING, OCTOBER 16TH

Written in 1923 by Bernard Shaw
Directed by Neil Munro

“What do you do with someone who has an overpowering vision of what the world might be? These visions lead us forward — sometimes into disaster (Lenin and Russia), sometimes into a new world (Franklin, Jefferson and America). At a moment of almost total defeat what was left of the French government listened to Joan of Arc because nobody else had any ideas. She gave them success beyond their wildest dreams. Then they discarded her. This is one of the great plays of our time and so pertinent in our world where we are alternatively crying out for visions and in the next moment running terrified from them.”

- Christopher Newton
Artistic Director

All-Day Workshop: Moving the Profession of Dental Hygiene Towards the Year 2000

Dental hygiene educators and licensing body representatives wishing to explore the profession of dental hygiene as it moves in new directions will be interested in this workshop. Participants will have the opportunity to learn about and investigate current issues in dental hygiene education standards, dental hygiene accreditation standards, including the CORE process, National Certification, and continuing competence. The workshop format will promote a sharing of ideas and concerns in both large and small groups. Clinical practitioners interested in attending please contact **Susanne Sunell** at (604) 443-8505 or Fax (604) 443-8588.



Registration for Friday Workshop Only

Date: Friday, October 15, 1993 **Place:** Sheraton Fallsview Hotel, Niagara Falls, Ontario
Time: 9:00 to 4:00 **Registration Fee:** \$35.00 (includes lunch)

Information from Registrants:

Name: _____

Address: _____

Current Dental Hygiene Involvement:

Identify the area in which you spend the major part of your time:

☐ Community Health ☐ Licensing Organizations ☐ Clinical Practice

☐ Education _____ ☐ Other _____

(if yes, name of program)

Participant Expectations: What do you hope to gain from the workshop? Do you have a particular question you would like to have addressed? _____

**Pre-registration is critical
to allow for scheduling
of facilities and the
organization of the
working groups.**

**DEADLINE FOR REGISTRATION:
SEPT. 15, 1993**

MAIL REGISTRATION TO:

Susanne Sunell, RDH
c/o The Canadian Dental
Hygienists' Association
1018 Merivale Rd., Suite 201
Ottawa, Ontario
K1Z 6A5

Registration Form 1993

CDHA/ADHA Member

Full Registration	on or before Sept 1, 1993	\$215.00 (GST incl)	Daily Registration	on or before Sept 1, 1993	\$105.00 (GST incl)
	after Sept 1, 1993	\$265.00 (GST incl)		after Sept 1, 1993	\$130.00 (GST incl)

Students (Full-Time Dental Hygiene Only)

Full Registration	Free	for lectures only; does not include socials or meals
	or	\$100.00 (GST incl) includes luncheons, breaks and reception
Daily Registration	Free	for lectures only or \$40.00 includes lunches and breaks

Non-Members

Full Registration	\$400.00 (GST incl)	Daily Registration	\$215.00 (GST incl)
--------------------------	---------------------	---------------------------	---------------------

Full Registration includes access to professional programs, reception, breaks and luncheons

Daily Registration includes access to professional programs of the day, plus lunch and breaks

Niagara-on-the-Lake Shaw Festival — "St Joan" approx. \$80.00 Limited Attendance (incl transportation)

Note: Pre-registration for workshops — due to limited space for the workshops, please indicate your workshop choice at the time of pre-registration.

Make cheques payable to the CDHA and mail to :

Early-bird draw

Registrations received prior to Sept 1, 1993 are eligible to win:

Free registration and 2 nights free accommodation at

Sheraton Fallsview at the time of the Conference.

Cancellation Policy

If cancellation notice is received **in writing** prior to Sept 1, 1993,

a refund less \$25.00 administration fee will be issued; after Sept 1, 1993,

a 50% refund will be issued.

CDHA Conference, Suite 201, 1018 Merivale Rd., Ottawa, Ontario, K1Z 6A5

Cheque ☐ Amount _____
or Visa number _____ Expiry date _____ Signature _____ Amount _____
Name _____ CDHA ID# _____
Address _____ City _____ Prov. _____ Postal Code _____
Telephone: Res (_____) _____ Bus (_____) _____

Please indicate following: Number of tickets for Shaw Festival — "Saint Joan" _____

Interest in attending workshops:

☐ Theory Development	☐ Testing & Validating Dental Hygiene Theory	☐ Survey Research
☐ Qualitative Research	☐ Common Flaws in Research	

Vegetarian ☐ Yes ☐ No

Please indicate any food allergies: _____

Sheraton Fallsview Reservations

Group: Canadian Dental Hygienists Research Conference
Dates: October 15-17, 1993 Group Code # G2412
Name: _____ Company: _____
Address: _____ Postal Code/Zip: _____
City/State/Prov.: _____ Telephone: _____
Sharing room with: _____
Arrival Date: _____ Departure Date: _____
Check in time is 3 pm *Check out time is 11 am*
Block of rooms held until September 15, 1993
☐ City View **\$86.00** ☐ Falls View **\$116.00** *Single or Double Occupancy Fax: (416) 374-6224

To confirm and guarantee your first night's deposit, please indicate your American Express, Visa or Mastercard credit card number.

Card type _____ Number _____ Expiry Date _____

If room rate and category requested are not available, the next available rate will be assigned. All rates are quoted in Canadian funds.

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Key Elements of the Ontario Regulated Health Professions Act

By:
Linda Strevens, BScD

The Canadian medical health care system which is primarily financed by each individual province, is publicly administered and, in general, does not restrict individuals from attending a practitioner of choice. Legislation affecting all health professions falls under provincial jurisdiction.

Prior to the end of 1993, a new health regulatory legislation will be implemented for the province of Ontario. Underlying issues relative to specific provisions of the new legislation recognized that a better regulatory system for Ontario was needed. The existing laws governing many health professions and, more specifically, dentistry and dental hygiene in Ontario, as outlined in the *Health Disciplines Act* and the associated regulations, prevented health care providers, other than physicians and dentists, from making the most effective use of both their skills and/or health dollars that paid for them.



LINDA STREVEVS, BScD

from among a variety of health providers. The result — *The Regulated Health Professions Act*. The Act will grant 24 health professions in Ontario the privilege of self-regulation. The sole purpose of professional regulation is to advance and protect the public interest. Self-regulation acknowledges the special knowledge of a profession and allows it to act as an agent of government in regulating its own members. Members of the profession are elected by their peers to safeguard the public's interest in the practice of the profession, not to represent their economic and professional interests.

The new legislative structure provides an all encompassing omnibus act called the *Regulated Health Professions Act* and a procedural code which contains requirements, structures and procedures common to all 24 governing bodies. It also contains the majority of organizational, legal and procedural provisions that once again apply to all of the 24 health professions. The structure contains 21 profession-specific acts with 3 professions being grouped under other health professional acts. These 21 professional acts contain provisions specific to each profession, including such matters as Council composition, scope of practice, authorized acts and specific provisions unique to the profession. For Ontario dental hygienists, the new legislation will affect registration, enforcement of conduct and quality assurance functions.

Bill 43, now called the *Regulated Health Professions Act*, and the 21 profession-specific acts received Royal Assent on November 25, 1991. The legislation, however, will not come into force until proclamation which is projected for late 1993.

As mentioned previously, the new legislation replaces the outdated *Health Disciplines Act* and statutes of other health professions. It regulates, for the first time, the professions of Audiology, Dietetics, Medical Laboratory Technology, Midwifery, Occupational Therapy, Respiratory Therapy and Speech-Language Pathology. After 41 years of being regulated by dentistry, the profession of Dental Hygiene will become self-regulating for the first time. Other professions currently regulated by existing patchwork legislation which will fall under the new Act are: Chiropractic, Chiropractic, Dentistry, Dental Hygiene, Dental Technology, Denture Therapy, Massage Therapy, Medical Radiation Technology, Medicine, Naturopathy, Nursing, Opticianry, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry, and Psychology.

In 1982, an extensive review of all health professions' legislation began at a time when pressure for change was being exerted by the government of Ontario, the public and even the health professions. The team responsible for the review were not health professionals or government officials but rather, advisors who gathered information by consulting with all stakeholder groups. The team's report provided recommendations that struck a balance between the issues and objections surrounding not only too much de-regulation of some health professionals, but over-regulation of others. In addressing the issue of turf protection, the balance was not to enhance a profession's status or to increase the earning powers of its members by giving the profession a monopoly over the delivery of particular health services but, rather, to make better use of the range of health care providers and the services they deliver. Allowing the consumer, therefore, more choice for care

"The existing laws governing many health professions... prevented health care providers, other than physicians and dentists, from making the most effective use of both their skills and/or health dollars that paid for them."

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The *Regulated Health Professions Act* addresses policy reforms that increase public protection; increase public accountability; and enhance public policy. It opens the door to the reality of a multidisciplinary health care system where the practice of various professions overlap. Unique to the legislation are the following legal and procedural reforms:

- greater accountability whereby public representation on College Councils will increase to just under half of the total membership;
- open Council meetings, discipline hearings, complaints reviews and registration hearings will provide a more open system to the public and in turn a more accountable system;
- a Health Professions Regulatory Advisory Council composed of all public representatives will be established to advise the Minister of Health on regulatory matters such as which unregulated professions should be regulated, and the effectiveness of regulatory structures;
- mandatory quality assurance programs to ensure that members maintain their competence throughout their professional lives; that the treatments used are effective and that health services are appropriate to patients' needs;
- better compatibility with improved methods of accessing information from College registers will be implemented, thus allowing the public the opportunity to receive information about discipline matters involving practitioners; and
- formal annual reporting to the Minister of Health of the Ontario government.

Key to the new legislation is the concept of controlling potentially dangerous procedures. Two of the elements unique to the new legislation are a general scope-of-practice statement describing the overall ambit of the profession and the control of specific acts restricted to authorized professions. No longer will individuals be licensed, but rather, the functions they do will be licensed, authorized or controlled. It is evident that some of the activities performed by health care providers pose a risk of harm if they are performed by unqualified persons. However, it is equally true that some health care services are not intrinsically hazardous. Only health professionals with the right skills and training will be permitted to perform the controlled acts which, as mentioned previously, have been defined as those activities considered to be hazardous or potentially dangerous. By not controlling all other services and low risk activities, the new laws will give consumers more freedom to choose from any health care provider.

Altogether, there are 13 categories identified as controlled acts, capturing every potentially hazardous health care activity. Some of these categories are highlighted below. Using the exact wording outlined in the legislation, the first two examples are described as:

- **cognitive (e.g., diagnosis)** — communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
- **physically invasive or manipulative** — specific to dental hygiene is this example which is stated as: performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

A few other generic areas relative to categories identified as controlled acts include:

- **hazardous forms of energy** (e.g., laser treatment)
- **drugs** — prescribing, dispensing, selling or compounding a drug
- **prescribing vision care appliances and hearing aids**
- **allergy testing** — of a kind in which a positive result of the test is a significant allergic response

“No longer will individuals be licensed, but rather, the functions they do will be licensed, authorized or controlled.”

As indicated previously, one of the key elements of the *Regulated Health Professions Act* is the general scope-of-practice statement. The statement describes what the profession does, the methods it uses, and the purpose for which it is intended. In describing the area of practice, it allows the governing body to establish entry requirements and standards of practice. The statement outlines for consumers, members of the profession, employers and courts, the proper range of the profession's scope of practice and for the educators the statement may be used to guide them with curricula design and update. The new scope-of-practice model will provide equal standing to a larger number of regulated health professions, as there will be more opportunities for different professions to work together.

The profession-specific act for dental hygiene, The *Dental Hygiene Act* outlines in section 3 the scope of practice statement for dental hygiene as:

“3. The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and the provision of restorative and orthodontic procedures and services.”

This scope of practice statement describes what the profession does, the methods it uses, and the purpose for which it is intended.

The dentists' scope of practice statement as contained in the Dentistry Act states that:

“3. The practice of dentistry is the assessment of the physical condition of the oral-facial complex and the diagnosis, treatment and prevention of any disease, disorder or dysfunction of the oral-facial complex.”

The key word here is “diagnosis”.

Of the 13 controlled acts under the *Regulated Health Professions Act*, dental hygienists are authorized to do two, as described in section 4 of the *Dental Hygiene Act* as:

1. scaling of teeth and root planing including curetting surrounding tissue
2. orthodontic and restorative procedures

However, before a dental hygienist can carry out these procedures, a condition must be met:

"5(1) A member (dental hygienist) shall not perform a procedure under the authority of section 4 unless the procedure **is ordered** by a member (dentist) of The Royal College of Dental Surgeons of Ontario."

The interpretation of the term "is ordered" will be addressed during the development of the specific regulations, keeping in mind two of the fundamental elements of the new legislation: accessibility to care, and choice of health care provider by consumers. No doubt, questions will be raised specific to a dental hygienist's practice setting. For example, perhaps the term "order" will mean that after the dentist has completed a diagnosis and established the patient's treatment plan, a dental hygienist upon receiving the order will be able to execute the dental hygiene services to the patient independent of the dentist's presence. However, this could only occur in accordance with applicable regulations which, as yet, have not been drafted.

The element of total quality management/quality assurance is also paramount to the new legislation. The objective is to provide for more effective and efficient patient care services by continually improving all the processes that affect patient outcomes. Three years after the *Regulated Health Professions Act* becomes law, every health professions College must have a quality assurance program in place.

Allowance in the new legislation specific to quality assurance provides for the:

- appointment of assessors;
- inspection of premises;
- inspection of records; and
- referral of a member to the Executive Committee

The quality assurance program is intended to ensure that members maintain their competence throughout their professional lives, that the treatments used are effective and that health services are appropriate to patients' needs. This will require a more active approach to improving the quality of services provided by the profession as a whole. Attention is focused more on improving the norm rather than only dealing **reactively** with individual "outliers".

The College of Dental Hygienists will be established upon proclamation of the *Regulated Health Professions Act*. It has been identified that the Council of the College will range in number from 19-25 members with: 9-12 elected from the profession; 8-11 appointed by government; and 2 selected from an educational institution in Ontario that grants a diploma or degree in dental hygiene.

The College will be mandated to have seven statutory Committees/Programs. The mandate and composition of these committees are outlined explicitly in the *Regulated Health Professions Act*.

Under the new Act, the title dental hygienist will be a restricted and protected title to be used only by professionals who hold a certificate of registration as a dental hygienist.

Prior to the establishment of the new governing body, a transitional phase of transferring governance from The Royal College of Dental Surgeons of Ontario to the College of Dental Hygienists will occur. A

Transitional Council for the College of Dental Hygienists was appointed by the government in October, 1992. It is composed of six dental hygienists and six public representatives.

The Transitional Council's mandate includes:

- establishing officers and committees of Council;
- developing regulations;
- establishing an administrative infra-structure;
- establishing a credentialing process for registration; and
- developing by-laws for the new College

Issues such as interpreting the phrase "**is ordered**", ensuring that dental hygienists have adequate malpractice insurance coverage, and implementing alternate practice settings are all areas that will be addressed by the Transitional Council.

In summary, the structure of the new legislation allows for: better accessibility to care whereby consumers will be able to choose and seek care from a larger number of regulated professionals; accountability of professions whereby greater public representation will be active on the Councils and Committees of the Colleges; and finally affordability of care, which to some extent will be targeted through the implementation of the quality assurance programs in identifying practitioners who are using inappropriate and unnecessary treatment methods relative to patients' needs.

Perhaps the future will bring about global changes in recognizing dental hygiene as a self-governing profession and one that understands that the public is the intended beneficiary of regulation, not the members of the profession. Self-regulation is a privilege. A privilege that can be revoked if there is sufficient evidence to show that the profession is not serving the public's interest. The *Regulated Health Professions Act* as new legislation will ensure that the public of Ontario has a better regulatory system for the 90's and years to come. 

References:

Bill 43: An Act respecting the regulation of Health Professions and other matters concerning Health Professions, 1991

Bill 47: An Act respecting the regulation of the Profession of Dental Hygiene, 1991

Striking a New Balance: A Blueprint For The Regulation of Ontario's Health Professions; Recommendations of the Health Professions Legislation Review, 1989.

Linda Strevens, BScD, is the Executive Assistant of the Royal College of Dental Surgeons of Ontario, a position she has held since 1982.

Response of Dental Community to Family Violence Issues

By:
Jenny Thomas, DT, RDH, BA, MEd

Recognizing the importance of the family violence issue for all Canadians, even in a time of fiscal restraint and limits on social programs, the Federal Government in February 1991, awarded \$136 million to the Initiative on Family Violence. This four-year program builds upon two previous ventures, the 1986 Child Sexual Abuse Initiative which ended in March 1991, and the 1988 Family Violence Initiative which concluded in March 1992.

The success of the Federal Government's initiative will depend upon the partnership, collaboration, commitment and action of all Canadians from every walk of life. The goals are:

1. to involve all Canadian and mobilize community action in an effort to reduce family violence;
2. to strengthen Canada's legal framework for dealing with family violence;
3. to establish services in Indian reserves and Inuit communities;
4. to strengthen Canada's ability to help victims and stop offenders;
5. to provide more housing for abused women and their children;
6. to develop better national information on the extent and nature of family violence; and
7. to share information and solutions across Canada.



JENNY THOMAS, DT, RDH, BA, MEd

Fourteen federal departments are now working in partnership to achieve these goals. The Mental Health Division, Health and Welfare Canada, receives \$1 million over the four-year period and is specifically concerned with broadening health professionals' awareness of, and sensitivity to, family violence. As well, the Division will assist health service providers with responding appropriately and effectively to family violence by facilitating the development of training and resource materials. In addition, the program will encourage service providers, program planners, researchers and policy makers to consider mental health, family violence needs and issues within their health mandate.

Five areas have been selected for immediate attention:

1. **Curricula development and enhancement** — A Curricula discussion paper has been prepared which presents current practice in dealing with family violence issues across health professions.
2. **Continuing education and training** — Collaborative activities within the dental community, nursing and medicine are underway to assist with the dissemination of family violence information through journals, conferences and health care networks.
3. **Clinical guidelines for health practitioners** — The Canadian Nurses Association has already developed guidelines. These were published in the December 1992 issue of the *Canadian Nurse*.
4. **Approaches and guidelines for community service providers** — "Community Awareness and Response: Abuse and Neglect of Older Adults" was developed, in a collaborative effort with the four western provinces, for national distribution in Spring 1993.
5. **Prevention and risk reduction strategies** — Several publications were developed dealing with building healthy relationships for young people, and promoting sensitive and effective youth programs and policies.

Areas for future attention include curricula and training issues,

"The success of the Federal Government's initiative will depend upon the partnership, collaboration, commitment and action of all Canadians from every walk of life."

adoption of the recently published guidelines for all health professions, workplace awareness (prevention and early referral), evaluation of publications and resource material, and enhanced access to health/family violence materials.

The Canadian Dental Hygienists Association was asked by the Health Services Directorate, Health and Welfare Canada, to nominate a representative to the ad hoc advisory group on the Dental Community's Response to Family Violence Issues.* The Canadian Dental Association and the Canadian Dental Assistants Association are also represented. The purpose of this group is to advise Health and Welfare in planning initiatives with the dental community, and stimulating awareness and interest in this important issue of family violence.

"There is an opportunity for all of us, as dental hygienists, to encourage increased awareness of this problem within our practice, and respond sensitively to this issue."

As the CDHA representative on this committee, I am excited not only at the speed at which things are being accomplished, but at the prospect of the role dental hygienists can play in assisting the government to achieve its goals. All of us can challenge the attitudes that underlie family violence and act when someone is being threatened or hurt. None of us can afford to think or act as if family violence were somebody else's problem.

Health issues related to family violence reach well beyond physical health to include issues of individual and collective mental health. Survivors are affected in many areas of life; e.g., self-image, capacity to build stable relationships, and approaches to parenting. As health professionals on the "front line" who are sensitized to family violence issues, we can respond appropriately in our day-to-day work. We can play a pivotal role in the identification, referral and support of these individuals.

There is an opportunity for all of us, as dental hygienists, to encourage increased awareness of this problem within our practice, and respond sensitively to this issue.

Probe will be running a series of articles on this topic over the next year. CDHA central office is compiling a file of relevant resource material, and welcomes your contributions and information. Please contact CDHA at 1018 Merivale Road, suite 201, Ottawa, Ontario K1Z 6A5.

Sources

Canada's Mental Health Vol. 40 no 1. March 1992. Health and Welfare Canada.

Family Violence Initiative Fact Sheet. Health and Welfare Canada.

Simpson, J. Overall Funding Mandate for the Mental Health Division within the Federal Family Violence Initiative 1991/92-1994/95. Health Services and Promotion Branch, Health and Welfare Canada.

***Editor's note:** The Working Group was struck in the fall of 1992, by the Mental Health Division, Health Services Directorate, Health and Welfare Canada, and will complete its mandate in August 1993. Joan Simpson, Family Violence Co-ordinator, Mental Health Division, Chairs this Advisory Group, assisted by Sharon Amer, Advisor, Dental Health Standards, Health Service Systems.

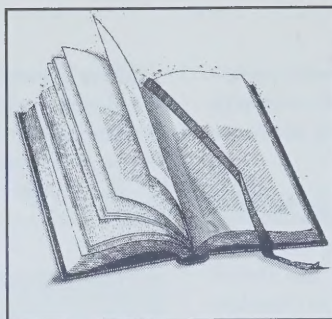
Jenny Thomas, now of Ottawa, is a Dental Hygiene Consultant with Experient Consultants Inc. Upon arrival from her native Britain, she studied for a Bachelor of Arts degree in 1972, from Carleton University. She has been actively involved in the dental hygiene profession for twenty years, and worked at the Ottawa Civic Hospital for six years, stimulating her interest in gerontological issues. She recently completed her Master's in Education at Ottawa University.



It Shouldn't Hurt to be a Child

Victims of Violence International B150 151 Slater Street Ottawa Canada K1P 5H3
US - Post Office Box 1305 Ogdensburg NY 13669 (613) 233 0052 FAX 233 2712

Original artwork by 16-year-old Vincent Sinclair, Jasper Place High School, Edmonton, AB.



Book Reviews

Infection Control for the Dental Team

L.P. Samaranayake, Flemming Scheutz, James A. Cottone (Authors) First edition, first printing, Munksgaard Publishers, Copenhagen, Denmark. Copyright 1991. Illustrated, 143 pages.

Reviewed by Patricia Fortier, RDH, Orthodontic Dental Hygienist, Part-time instructor of Dental Hygiene, Niagara College, Welland, Ontario.

The publication of this little book (20.5 cm by 12.5 cm) could not have been more timely. As discussed in the book's introduction, we are intensely aware that any dental treatment presents an infection control problem, even potentially lethal infections such as HBV and HIV can be transmitted in the dental office. Some authorities recommend extensive guidelines of infection control, perhaps being over-zealous and over-cautious. A number of recent studies have shown the extremely low infectivity of HIV in dentistry and as a result the current guidelines for infection control reflect a more common-sense approach to cross-infection in dentistry. In this vein, the book is written for every dental facility and every person on the dental team. It provides a concise practical and comprehensive approach to the control of micro-organisms.

The book is small enough to be stored easily in a drawer in the sterilization area, or chair-side, thus lending itself to quick reference.

The text is succinctly written and well organized. A "Glossary of Terms and Abbreviations" is included at the back of the book. The "Selected References" given at the end is an extensive and impressive synopsis of the most current information on this topic by renowned, international authors.

The topics covered are: "Micro-organisms and their properties", "Infection and the Spread of Micro-organisms", "Infectious diseases of Special Concern in Dentistry", (this list is very extensive), "Patient Evaluation and Personal Protection", "Principles of

Sterilization and Disinfection", "Infection Control in the Laboratory", "Instrument Recirculation and Office Design", "High-Risk Patients and Health Care Workers Belong to High-Risk Groups". Each chapter is followed by a summary page which facilitates review.

Allied dental health personnel, faculty and students will find this mini-volume a must for their libraries.

Understanding Periodontal Diseases

Joel M. Berns (Editor). Quintessence Publishing Co Inc., 551 North Kimberly Drive, Carol Stream, Illinois, 60188-1881. Illustrations (32 colour), 74 pages. ISSN: 0-86715-239-7.

Reviewed by Carol M. Barr Overholt, RDH, Faculty, Niagara College Dental Hygiene Program, Welland, Ontario.

While we are fortunate to have numerous texts available to us on the study of periodontics, few of us would feel comfortable with opening one and handing it to a client for clarification of a point. As dental hygienists we have a working knowledge of the current philosophies of etiology and prevention of periodontal diseases. It is sometimes difficult, however, to convey the more involved concepts to the client. Quintessence Publishing has identified this as a need, and provided the profession with *Understanding Periodontal Diseases*, one of six in a client-information series.

This issue addresses periodontal diseases in three parts. Part I is an information overview of the signs, symptoms and causes of the diseases and how preventive measures may intercede to slow or halt the process. The "step-by-step" chain of events leading to tooth loss follows in Part II, proceeding neatly into Part III covering modes of treatment available to the client.

Upon opening the edition, the reader instantly notes the large type, no doubt a

significant feature for our senior clients. The large, hand-drawn illustrations are pleasing to the eye and are of medical-illustration quality in exactness. They are, however, simple in detail and allow the non-dental reader to make sense of the periodontium and its workings. Relevant words or phrases are italicized or block-printed for emphasis and lay-terms are used wherever possible.

The layout of each page centres the topic of discussion as a single point. This signifies the importance of each individual issue; this "bite-sized" approach assists the reader in following and assimilating the facts at a manageable pace.

An important issue, well addressed, is the periodontal examination; what it involves and what it tells the practitioner. The role of the specialist is examined including situations requiring consultation. Where suitable, client misconceptions are clarified: i.e., that the teeth are not housed within the "gums" but within the bone and that the gingiva is a "protective covering". A helpful feature of this publication is a concluding page for each of the three sections summarizing the previous subject matter.

The concluding chapter, covering treatment options, offers a brief oral hygiene overview which would require substantial follow-up by the dental hygienist; toothbrushing methods, correct flossing technique and adjunctive preventive aids are not discussed. I was pleased to see that the author also indicates that the need may arise to assess the potential necessity of a flap procedure for adequate debridement during the professional removal of calculus and plaque. The client is also encouraged to have restorations/prosthetics evaluated, along with occlusion, as part of a thorough appraisal.

The paragraph on professional dental maintenance causes me some reservation: I am reluctant to commit to a standard time-frame for scaling/re-evaluation recall appointments. It recommends three-month intervals.

One other feature of this publication that bears reviewing is the method of binding. The soft cover and glued spine make it difficult to open the pages fully which might be required when reading the text with a client. I would suggest a coil-bound, or three-ring approach, with laminated pages for both durability and infection-control.

This observation aside, I would heartily recommend the edition for either the waiting room (as it may be read without professional assistance), or operatory, to clarify one of the more common issues surrounding periodontics. At under \$30 it is a small, but worthwhile, investment in dental health education and promotion.

An Illustrated Guide to Dental Care for the Medically Compromised Patient

M.C. Grundy, L. Shaw, and D.V. Hamilton (Authors). Wolfe Publishing 1993, Copyright 1993. Mosby - Year Book Europe Limited. Illustrated, 128 pages. ISBN 0 7234 1707 5

Reviewed by Marilyn J. Goulding, Dental Hygiene Faculty, Niagara College, Welland, Ontario.

The aim of this book is to "provide information to enable the dentist to understand better

the more common conditions that he/she will be met with in the care of those people who are medically compromised and may have special needs".

This book provides an overview of many of the disorders and is laid out in sequence of the body systems. This is an appropriate style for teaching as many pathophysiology course outlines progress in a similar manner.

This arrangement can be problematic in the sense that some disorders cross several of the systems and may be lost altogether. One example is lupus erythematosus. The authors may consider including a section on the immune system and its disorders; the missing diseases may find themselves a home in a chapter of this scope.

The photo plates are in full colour and are presented with excellent clarity. They are, however, inconsistent in their coverage of the text. Some chapters have several photographic examples while others, are bereft of adjunctive pictures; examples are phenylketonuria, the neuromuscular section, and juvenile arthritis.

The last section on "Problems Related to the Prevention of Oral Disease" includes an

array of subjects which may be better represented under the "systems" theme introduced by the authors for the remainder of the book. The title "Preventive Therapy", also under this section, appears to be standard fare with little or no reference to its application to the medically compromised patient.

From an editorial standpoint there are those few typographical and spacing errors that tend to plague first-time publications. The authors may be well advised to consider less font and format diversities in the next printing. The mixture of large bold, smaller bold, and italicized print is unsettling to the reader's eye. The photos need only one number for identification and those with reference to previous photos could forego the bold type.

This is a good clinical reference text. It gives fundamental information in a quick-to-find and easy-to-read format. I feel it is very well suited to the dental hygiene student and would be a valuable addition to any clinic or reference library. Teachers of pathophysiology would not find it comprehensive enough for their purposes but the dental slant makes it good for supplemental reading. 

Interested in Practising in B.C.?

The College of Dental Surgeons of B.C. has developed a Waiver Program (exemption from all Board Examinations) for dental hygienists applying for Registration and Licensure for the period January 1, 1992 to December 31, 1994. Dental hygienists may qualify if they are:

- 1) graduates of a dental hygiene program accredited by either the Canadian Dental Association or the American Dental Association;
- 2) not considered to be an unsuccessful candidate in their most recent Board Examination attempt in any province or state;
- 3) can provide a letter of good standing from the licensing jurisdiction in which they are currently, or last licensed and/or are graduates within the previous year.

The College will also review each applicant's practising history prior to making a determination as to eligibility.

For more information, and to obtain application packages, please contact

**The Registrar, College of Dental Surgeons of B.C.
500-1765 West 8th Avenue, Vancouver, BC V6J 5C6
(604) 736-3621 or fax: (604) 734-9448.**



Calendar

June 1993

		<i>SPONSOR</i>	<i>LOCATION</i>	<i>FOR INFO CALL</i>
10-11	Root Planing Therapy	University of Alberta	Edmonton, AB	(403) 492-5023
12-13	Enriching Clinical Competence: A Root planing workshop	NAN-KES: Partners in Education	Vancouver, BC	(604) 942-5785
20-25	Dental Hygiene Refresher Course	Dalhousie University	Halifax, NS	(902) 494-1674

July 1993

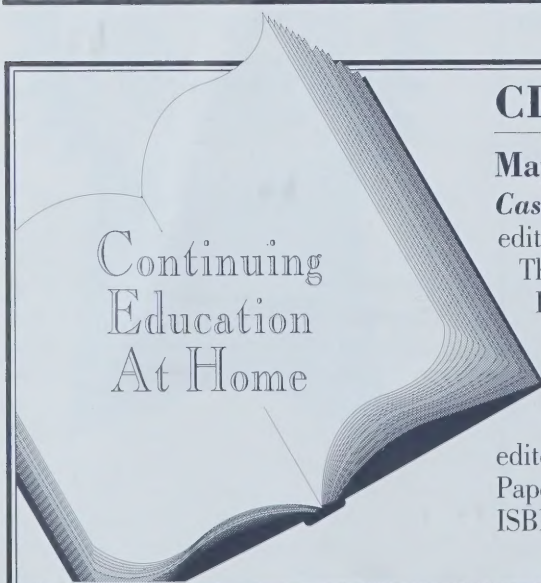
5-16	Dental Hygiene Refresher Course	George Brown College	Toronto, ON	(416) 944-4556
6-12	Dental Education in the Care of the Disabled	University of Washington	Washington, DC	(206) 543-5448

September 1993

23	Evening Program in Periodontics	University of Toronto	Toronto, ON	(416) 979-4503
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October 1993

15-17	CDHA's Professional Conference — An Exploration into the Future: A North American Research Conference	Canadian Dental Hygienists Association	Niagara Falls, ON	(613) 728-8730
23-24	Preventive Dentistry Forum	University of Toronto	Toronto, ON	(416) 979-4503



CDHA's Book of the Month Suggestion

May:

Case Studies in Canadian Health Policy and Management (vol. 1)

edited by Raisa B. Deber.

The Canadian Hospital Association. Copyright 1992.

ISBN 0-919100-47-3

June:

Health Care

Innovation, Impact and Challenge

edited by S. Mathwin Davis

Papers presented at a conference held at Queen's University in June 1992

ISBN 0-88911-639-3

A white toothbrush with a blue textured grip and a flexible neck is shown against a dark blue background. The neck is bent into a U-shape, demonstrating its flexibility. The brush head is white with dual bristles. The word "Aquaflresh" is printed in blue on the handle.

FLEX™-ABILITY

Introducing Aquaflresh Flex.™
The first brush with a flexible neck
to help relieve brushing pressure
on gums.

Clinical tests have proven that Flex is gentle on gums, thanks to its unique pressure sensitive neck, that flexes to prevent gum irritation.

No other brush is more effective than Aquaflresh Flex at reducing plaque, the main cause of gum diseases like gingivitis.

Recommend new Flex to your patients for healthier teeth and gums.

- Clinically-proven cleaning ability
- Angled, tapered head
- Dual bristles
- Non-slip rubber grip

Aquaflresh
FLEX™

For gentle dental care

SmithKline Beecham Consumer Brands Inc.

National Dental Hygiene Campaign 1993

October 17-23



It is the second year of the "Behind every great smile..." campaign, and for 1993 CDHA and Procter and Gamble have joined together in a partnership to promote personal and professional dental care to school-age children in Canada.

The goal of National Dental Hygiene Campaign is to promote the awareness of Dental Hygiene as a distinct profession and to facilitate health promotion activities which will contribute towards improving the public's overall health. This year's special fact sheets on fissure sealants and mouth care for children will be printed in English and French. There will also be stickers for children, and a poster which comes in two sizes. Samples of these items, plus instructions for a fluoride egg experiment will be included with the July/August edition of *Probe*. Plus a special CDHA travel mug will be available.

To become involved — first contact your provincial co-ordinator (names and addresses given on the following page), to find out what is being planned in your area. Then,

get together with a group of colleagues to devise some more activities. If perhaps you do not know any other hygienists locally, ask your provincial co-ordinator for names. But don't give up if you are alone, individual endeavours are encouraged! Provincial co-ordinators will also help you with obtaining media coverage. And do inform them of your activities — many interesting events go unrecorded. So ask for an Evaluation Form and remember to return it, duly completed. These forms are very important in planning future campaigns.

Some suggestions for this year:

- Visit elementary schools, community centres, lunch rooms, church groups, Brownie or Cub groups.
- Offer to sponsor a field trip to your dental office
- Set up displays in restaurants geared for children
- Place the logo on milk cartons
- Target children's television programs, day programs for stay-home parents

- Put up posters in schools, malls and waiting rooms

Topics to discuss:

- What is a dental hygienist, and what does she/he do?
- Brushing and flossing techniques — with demonstrations
- Nutrition counselling
- What are good, and bad, snacks
- When to eat Halloween treats
- Suggest giving toothbrushes and/or floss for Halloween.

As a reminder — the Older Adult poster and series of fact sheets are still available. And so are the "Behind every great smile" sweatshirts! See the order form on page 107.

Get active in promoting your profession — each activity broadens the awareness of personal and professional dental care to the public.

Dawn Mueller
National Dental Hygiene Campaign Co-ordinator

Provincial Campaign Co-ordinators

Newfoundland

Pamela Vokey
Central Newfoundland Health Unit
PO Box 2222
Gander, NF A1V 2N9
H(709) 256-7220 B(709) 651-3306

Prince Edward Island

Julie Muise
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RR #3
Charlottetown, PE C1A 7J7
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Nova Scotia

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H(514) 631-1915

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H(204) 326-1190

Saskatchewan

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H(306) 789-2858

Alberta

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St. Albert, AB T8N 5Y6
H(403) 458-3325

British Columbia

Jo Gardner
PO Box 151
Madeira Park, BC V0N 2H0
H(604) 9209
Karen Gallagher
16275 87th Ave
Surrey, BC V3S 7S3
H(604) 572-9110

Canadian Forces

Denis Cote
BFC Valcartier
Courcellette, PQ G0A 1R0

National Campaign Co-ordinator

Dawn Mueller
131 Douglas Shore Close SE
Calgary, AB T2Z 2K8
(403) 720-0353

Order Form

Please print or type

Complete and mail to: **Canadian Dental Hygienists Association**
1018 Merivale Road, Suite 201,
Ottawa, Ontario K1Z 6A5

Name: _____

Address: _____ Suite #: _____

City: _____ Province: _____ Postal Code: _____

Telephone: () _____ CDHA Membership Number: _____

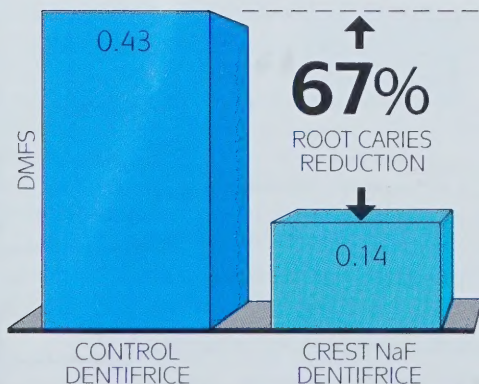
_____ Cheque/Money order enclosed _____ VISA Number: _____

Expiry Date: _____ Name of Cardholder: _____

Item	Quantity	Unit \$		Total
		Mem.	Non-mem.	
SCHOOL-AGED CHILDREN: (All Fact Sheets in pads of 50 with CDHA Logo only)				
Facts About Mouth Care		\$8.00	\$16.00	
Facts About Fissure Sealants		\$8.00	\$16.00	
POSTERS:				
Large with Crest-CDHA Logo		N/C	N/C	
Small with CDHA Logo		\$1.00	\$2.00	
Stickers with Crest-CDHA Logo	100	\$10.00	\$20.00	
Stickers with Crest-CDHA Logo	500	\$20.00	\$40.00	
Stickers with Crest-CDHA Logo	1000	\$30.00	\$60.00	
OLDER ADULTS:				
Facts About Mouth Care		\$8.00	\$16.00	
Facts About Gum Disease		\$8.00	\$16.00	
Facts About Denture Care		\$8.00	\$16.00	
Facts About Oral Cancer		\$8.00	\$16.00	
Poster		\$1.00	\$2.00	
GENERAL:				
Facts About Dental Hygienists		\$8.00	\$16.00	
Facts About Oral Care		\$8.00	\$16.00	
Facts About Gum Disease		\$8.00	\$16.00	
Facts To Remember		\$8.00	\$16.00	
CDHA Plastic Travel Mug		\$7.50	\$15.00	
SWEATSHIRT				
*Purple with white logo M L XL		\$25.00	\$50.00	
*White with purple logo M L XL		\$25.00	\$50.00	
*Please circle sweatshirt size				
Shipping & Handling All orders will be sent with prepaid shipping charges as follows: *Under \$29.00\$4.50 From \$30.00 to \$99.00\$7.00 Over \$100\$11.50 Over \$250.00 call our toll-free number 1-800-267-5235 for applicable charges.				Total Order Shipping (Total Order & Ship.) Sub Total Please add 7% GST (No. R106845233) to Sub Total Ont. residents please add 8% PST to Sub Total TOTAL
Phone orders accepted for VISA 1-800-267-5235				



CREST IS CLINICALLY PROVEN TO HELP PREVENT FRUSTRATING ROOT CARIES



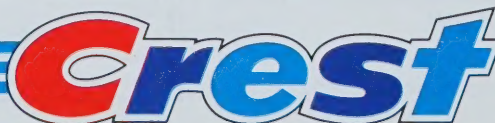
We don't have to tell you about the difficulties and frustration in treating certain root caries*, but we can give you some clinical information on prevention.

Crest with sodium fluoride has now been shown to reduce the incidence of root caries by 67% in a controlled clinical study involving 810 adults over 54 years of age.¹ And, considering a National Institute of Dental Research oral health survey reported 25% of patients over

age 40 have at least one carious or filled root surface lesion,² that's important to know.

So give your patients the clinically proven advantage against root caries that only Crest has been shown to offer. Recommend with confidence.

References: 1. Jensen ME, Kahout F: The effect of a fluoridated dentifrice on root and coronal caries in an older adult population JADA 1988, 117:829-832. 2. 1985 NIDR adult oral survey Oral Health of United States Adults (1985-1986)



Clinically recommended for root caries

PAAB
CCPP

*On exposed root surfaces



"Crest contains sodium fluoride which is, in our opinion, an effective decay preventive agent, and is of significant value when used in a conscientiously applied program of oral hygiene and regular professional care." CANADIAN DENTAL ASSOCIATION

Self-Assessment Test

White Lesions

1. A white line seen on the buccal mucosa extending anteroposteriorly along the occlusal plane is termed:
 - a) lichen planus
 - b) linea alba
 - c) leukoedema
 - d) hyperkeratosis
2. The above is considered a variation of normal:
 - a) true
 - b) false
3. An opalescence of the buccal mucosa characterized clinically as a grey-white film that cannot be removed is known as:
 - a) lichen planus
 - b) linea alba
 - c) leukoedema
 - d) leukoplakia
4. An oral surface infection often associated with clients suffering from AIDS is:
 - a) leukoedema
 - b) leukoplakia
 - c) candidiasis
 - d) lichen planus
5. Leukoplakia, a clinical term for a firmly attached lesion:
 - a) cannot be wiped off
 - b) can be wiped off but leaves a red ulcerated surface
 - c) is often a premalignancy
 - d) is caused by smoking
6. A white lesion usually seen on the lateral borders of the tongue, that is predictive of AIDS is:
 - a) leukoedema
 - b) white sponge nevus
 - c) lichen planus
 - d) hairy leukoplakia
 - e) white hairy tongue
7. Hyperkeratotic, white, plugged mucous ducts seen on the palate are often indicative of:
 - a) nicotinic stomatitis
 - b) carcinoma
 - c) measles
 - d) Fordyce's granules
 - e) white sponge nevus
8. Lichen Planus, an hyperkeratosis affecting several areas of the mouth, is clinically characterized by:
 - a) a white line on the buccal mucosa
 - b) a lace-like pattern on the tissue
 - c) a white plaque with a red border
 - d) a white soft fold on the buccal mucosa
9. An hereditary condition presenting as soft, white folds of tissue seen mainly on the buccal mucosa is:
 - a) leukoedema
 - b) white sponge nevus
 - c) pemphigus
 - d) lichen planus
10. Small, white ectopic sebaceous glands seen on the buccal mucosa or lips are called:
 - a) Epstein's pearls
 - b) gingival cysts
 - c) Fordyce's granules
 - d) leukoedema
11. A condition seen primarily in menopausal women, characterized by erosive/red areas of the gingiva, covered in a white epithelium and associated with a burning sensation is:
 - a) hyperkeratosis
 - b) necrotizing ulcerative gingivitis
 - c) pemphigus
 - d) desquamative gingivitis
12. An autoimmune disorder manifesting as large vesicles with a white necrotic epithelium and seen in older clients of Mediterranean origin is:
 - a) lichen planus
 - b) linea alba
 - c) pemphigus
 - d) desquamative gingivitis
 - e) candidiasis
13. Oral candidiasis often seen in association with which of the following:
 - a) median rhomboid glossitis
 - b) fissured tongue
 - c) macroglossia
 - d) hypertrophic tongue
 - e) geographic tongue
14. This fusospirochetal bacterial infection is characterized by interdental papillary necrosis, a white pseudomembrane and fetor oris:
 - a) pyogenic granuloma
 - b) epulis fissuratum
 - c) primary syphilis
 - d) necrotizing ulcerative gingivitis
15. Small, white keratinic cysts seen on the gingival pads of newborn children are:
 - a) Fordyce's granules
 - b) Koplik spots
 - c) Epstein's pearls
 - d) Stensen's papillae

Answers:

- | | | |
|--------|--------|--------|
| 1. b) | 2. a) | 3. c) |
| 4. c) | 5. a) | 6. d) |
| 7. a) | 8. b) | 9. b) |
| 10. c) | 11. d) | 12. d) |
| 13. e) | 14. d) | 15. c) |

This self-assessment test was prepared and written by Carol M. Barr Overholt, RDH, Faculty, Niagara College Dental Hygiene Program, Welland, Ontario.

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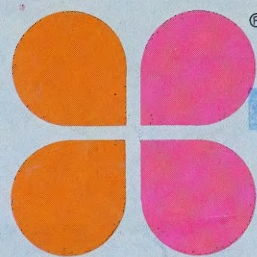


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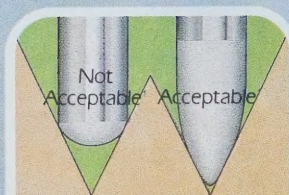
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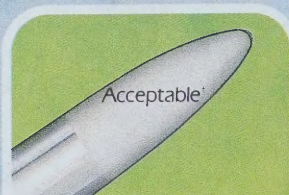
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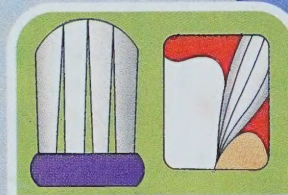
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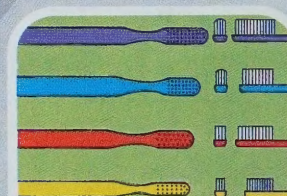
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VOL 27, NO 4

JULY/AUG 1993 JUILLET/AOÛT

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James Williams, RNDH

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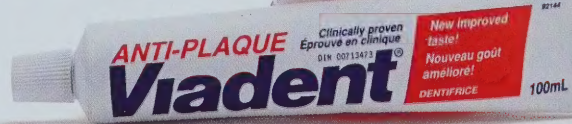
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References:

1. Hanna JJ, Johnson JD, Kufinec MM. Clinical evaluation of sanguinaria-containing toothpaste and oral rinse. American Journal of Orthodontics and Dentofacial Orthopedics, 1989, Vol. 3: 199-207
2. Harper DS, Mueller LJ, Fine JB, Gordon J, Laster LL. Clinical efficacy of a dentifrice and oral rinse containing sanguinaria extract and zinc chloride during six months of use. J Periodontol, 1990; 61: 352-358



My Driver's Licence??

"Have you looked at your driver's licence lately?"

"Of course, why just last week, a nice officer stopped me on my way to work and we reviewed it completely!"

"Ahh, but did you look at the back? Why don't you do that now, get it out and look at the back of your driver's license."

"This has nothing to do with driving, does it?"

"No, not in the travelling sense of the word, but looking at it as "provoking a movement", it has everything to do with driving."

"For those of you who can't find your wallets, we're talking about organ donation. The back of your driver's license is an official and legal organ donor card. When signed, it indicates your wish to save the lives of others."

"Of course I would like to save the lives of others, but this is a hard document to sign."

"Why is that? It's not complicated, just a signature."

"It makes me uncomfortable. It's not pleasant to think seriously of your own death."

"That's right, it is a serious decision, but one that could save the lives of many Canadians. The Traffic Injury Research Foundation figures show that the number of deaths by brain injuries in motor vehicle accidents has decreased substantially. This is, in part, due to health promotion activities which have successfully increased the use of seat belts, lowered the incidence of drunk driving and offered incentive for expanded education courses for new drivers. Medical technology has also played its part in continued advancements in surgical technique, making possible a wider nature of, and more viable outcome for, transplant operations. While all this is a celebrated victory over the more grim statistics of previous years, we must now address the ensuing problems; an increased number of potential recipients and a decreased number of organ donors."

Ms. Cheryl Rosell, Executive Director of the Multiple Organ Retrieval and Exchange Program of Ontario, says that "health professionals are working with the realities of fewer deaths caused by brain traumas but we also know that not all potential donors are being identified and their families approached. Hospital cutbacks may be considered a factor but I think that we can show that successful transplants help alleviate costs. If the number of donors in Ontario could be raised by just



MARILYN GOULDING, RDH, BSc

10% the health care system could save \$12 million dollars through kidney transplants alone. Each patient that progresses from treatment by dialysis to a kidney transplant saves the system \$145,618 over 10 years."

"If we look at the Canadian statistics: At the end of 1992 the number of patients on dialysis had more than doubled the 1981 statistics, from 3,293 to 6,877. Why, right now thousands of Canadians live full and vital lives due to successful transplants; Kidney — 6,313; Pancreas — 4; Kidney/Pancreas — 20; Liver — 597; Heart — 749; Heart/Lung — 26; Single Lung — 43; Double Lung — 54. Furthermore, there are currently 2,076 persons on the waiting lists for these organs. The dollars and lives saved associated with these numbers could make an outstanding difference in the lives of many our citizens."

"Wow, that's a great number of people in need. I would like to help but..."

"If you want to help, what is the problem?"

"Well, if the doctors see an organ donation card will they still try to save my life?"

"Everything that is medically possible will be done to save the life of a potential donor and the possibility of organ donations is not considered until brain death has been determined by at least two physicians who are not involved with transplants."

"What if they decide to retrieve my organs too soon? Haven't people been revived from what you call *brain death*?"

"Brain death is death. It occurs when a person has an irreversible, catastrophic brain injury which causes all brain activity to stop permanently. It is the clinical absence of brain function demonstrated by profound coma, apnea and absence of brain stem reflexes. It is an accepted medical, ethical and legal principle. Donated organs can be retrieved from a person who has been declared brain dead because the heart and lungs can continue to function for a limited time if the patient is left on a ventilator. The heart and lungs, however will stop functioning if left for more than 48 hours on the ventilator or if the ventilator is removed after brain death has been declared. In fact, there are seven steps in the organ donation process. These include; donor identification, donor referral and evaluation, declaration of brain death, consent for organ donation, donor maintenance, organ retrieval and finally, organ transplant."

"I don't understand; if I sign the organ donor card, why is there a step requesting consent for organ donation?"

"Although the donor card is considered to be a legal document, hospitals will not retrieve organs over the objections of next of kin. This is why it is important to let your family know your personal decision regarding organ donation."

"They may not object to my personal decision but they may not remember it during such a tragic time."

"Several of the provinces have, within the Public Hospitals Act, a mandate to establish the policies and procedures for identifying the donors and approaching their families. It has, in fact, provided many of the donor families with the only gift as profound as their grief, the opportunity to give life in the face of their loved one's death."

"So this can actually be part of the healing process for my family. I can help to save lives. I can assist in the fiscal management of our health care system. I can deal with the reality of my own mortality and have the satisfaction of some measure of control."

"Don't forget that you are a health care professional and, as such, are contributing to the moral and ethical principles of that profession. You're also helping to keep Canada one of the safest and best countries on this planet, to call home. You're taking part in being a proud Canadian!"

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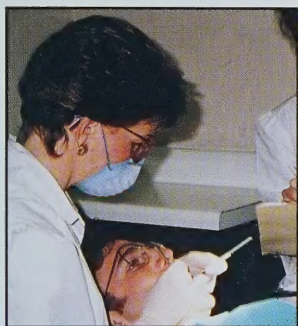
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COVER

Janice Williams is a 1977 Dental Hygiene graduate of Fanshawe College, London, Ontario. Her hygiene work experiences have included Public Health, solo practice, group practice, hygiene consultant with T.G. Assoc. and clinical instructor with the Niagara College Dental Hygiene Program.

She continues to be active in our professional associations at local, provincial and national levels. She is presently CDHA chairperson of the Research Fellowship Awards Committee.

In 1992, at the 12th International Symposium on Dental Hygiene, in The Hague, Netherlands, Janice presented her paper "Economy Study of a Two Chair Hygiene System."

Her interest and talent in the arts has lead her to perform with Shirley Yeszani School of Dance and to perform and choreograph for "The Treblaires", a ladies choral group, with productions at Brock University.

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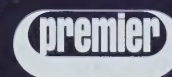
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FRAN RICHARDSON COTTON
RDH, BScD, MEd

Dental hygiene has come a long way since I began to practice in Ontario during the early 1970's. As I embark on this year as your president, I have chosen to reflect on the many changes that have occurred in the profession over the last 20+ years. Looking back over the past two decades, I perceive that the most dramatic changes have been in the areas of legislation and practice settings.

Certainly, there have been significant advancements in the areas of technology and clinical science, but, in my opinion, the single most profound change affecting our profession has been in the area of choice: choice as to *where* and *how* we practice our profession.

When I graduated, most dental hygienists entered private practice (most still do!); others chose to work in community health environments (then referred to as public health — that was me!); and maybe, after several years, a very few entered the world of teaching (not many since there were a limited number of dental hygiene and assisting schools in Canada at that time!). Those were also the days when our patients didn't know what our qualifications were and the term "dental hygienist" was new to many of them. Quite frankly, there just weren't too many of us around. My Ontario registration number is #538 and I can remember being the only dental hygienist within a wide geographic area.

I chose public health as my first practice setting because it was an opportunity that supplied me with a bursary to complete my education and required only a year's service in return. The experience was invaluable. I earned \$6,500 that year! Ever eager to learn, I later accepted an opportunity to experience

general practice and discovered that I not only had a flair for it, but I loved the work and enjoyed the personal interactions. Choice was limited in those days. For a change of pace from general private practice, most dental hygienists would enter either a periodontal specialty practice, an orthodontic practice, or (for the truly inspired) a paedodontic practice. There was talk that many of us worked for five years then quit to raise families — and, while many of us chose this path, we also chose to return to practice at a later date. Subsequent research has indicated that dental hygienists do remain in the profession and consider dental hygiene a career.

Today the choices for dental hygienists are widening. Many of our colleagues work for agencies that care for the elderly, the disabled, and the terminally ill. This is not an area that appeals to all of us. It takes an individual with unique gifts to dedicate one's working life to those who need special services and exceptional care. Another option for hygienists that has flourished in recent years is our role as educators. With the appearance of additional dental hygiene and assisting programs, many of us have opted to use our talents to advance the profession through teaching our future professional generation. Dental hygienists also teach in dental schools as part of the collaborative practice network. Let us not forget our dedicated colleagues who have chosen to work with the public in community health programs. Many of the advances witnessed in private practice are due to the spread of the oral health message in the broader context. Of course, the majority of us are still in private practice and dedicated to enhancing the health of the individual, one client at a time. However, with the increased choice in practice settings, we are discovering we work in a profession that offers practice modes to complement our individual gifts and talents — and this is at it should be.

The proclamation of new regulations and avenues for increased participation by dental hygienists on regulatory boards has paved the way for even more choices to become a reality. With our partners in other health professions, we are now in the position to promote quality oral care in a record number of settings. This variety will always include our collaborative working arrangement in private dental offices, but it will also extend far beyond this sphere for some.

As we continue to look towards the future, our professional association, the Canadian Dental Hygienists Association, dedicates

itself to ensuring that choice is available and imminently possible. We must also remember that increased choices for our profession extends beyond our own needs and offers improved choices for our patients and clients. They may choose to interact with us at the community health level and/or on an individual basis. They may choose to accept in-home care when necessity prevails, or they may choose to attend an educational facility for treatment rendered by students and faculty.

Just as our clients are all individuals with unique gifts, so too are we. Just as our colleagues in other health professions are unique individuals, so too are we. Each of us has special gifts; and each of us will soon have more opportunities to choose to use our talents in ways best suited to our individual personalities. CDHA is there to assist in this endeavour. CDHA is made up of individuals, all dedicated to the profession of dental hygiene. Canvassing the CDHA Board of Directors, one notes that just about all aspects of dental hygiene practice are represented. These professionals have chosen and been chosen to represent our colleagues across the country.

CDHA has moved towards a collaborative management system — one that places ownership for decisions on the Board of Directors. As your president for the 93-94 year, I am but one voice on that Board, but as your president I will speak and write on behalf of all Board members, and ultimately on behalf of our general membership. We are fortunate to live in a society that flourishes on freedom of choice; we chose to become members of this great profession; we are now coming into a time when we can choose where we want our profession to be in the year 2000.

Twenty years is a long time for some, a short time for others — but in the course of our profession it will ultimately prove to be but a moment in time. Take a moment now to reflect on your gifts and your practice choice. Isn't it wonderful that we are not all the same, but that we have all chosen to become dental hygienists?! 

Fran is currently Chair, Division of Dental Studies, College of New Caledonia, Prince George, BC. She received her Diploma in Dental Hygiene from the University of Toronto in 1971, a BScD from the University of Toronto in 1982 and a Masters in Education from the University of Regina in 1987.

National Dental Hygiene Campaign 1993

October 17-23



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Stickers with CDHA Logo	500	\$20.00	\$40.00	
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OLDER ADULTS:				
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Facts About Gum Disease		\$8.00	\$16.00	
Facts About Denture Care		\$8.00	\$16.00	
Facts About Oral Cancer		\$8.00	\$16.00	
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Facts About Gum Disease		\$8.00	\$16.00	
CDHA Plastic Travel Mug		\$7.50	\$15.00	
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Infection Control—The Debate Continues

Ms. Erikson, in her letter "Universal Precautions", (*Probe* Vol. 27, No. 2, Mar/Apr 93) makes a number of statements which promote further discussion. It is to be expected that some patients referred to a hospital based dental department would be medically compromised. Therefore, it should be no surprise that at least one of Ms. Erikson's patients per day would suffer from an immunodeficiency by exhibiting concomitant HIV, HBV, HPV, EBV, HSV infections along with candidiasis and T.B. However, it is entirely wrong to extrapolate from this that most dental patients have significant systemic disease. Surely Ms. Erikson does not believe that more than 50% of the patients attending the average dental practice are medically compromised?

Ms. Erikson does not understand the use of Universal Precautions. Their primary purpose is not to protect the patient, but to prevent health care workers from occupationally acquired bloodborne viral infections, principally HBV and HIV. They were introduced for this purpose in 1987, without any prior validation as to their effectiveness. Since Ms. Erikson believes them to be justified, I would ask her to provide verifiable scientifically documented proof that Universal Precautions protect patients from the transmission of bloodborne viral infections during dental treatment. At the same time, she might wish to unearth a single scientific publication that convincingly demonstrates that HIV causes AIDS.

It is debatable whether or not HIV is a new virus or an old one which modern technology has uncovered. In any case, Ms. Erikson will agree that HBV, HPV, HSV, EBV, TB., and candida albicans are not new pathogens, and that there is a remarkable paucity of evidence to suggest that they are readily transmitted via dental practice when traditional methods of infection control are employed. Accordingly, I would have no hesitation in being treated by her at Foothills Hospital, if she abandons Universal Precautions but, instead, washes her hands prior to performing intra-oral procedures and, for any surgically invasive procedure, utilizes instruments previously subjected to — at least — high level disinfection. After all, that is how the vast majority of Canadians have received their dental treatment, and in, the process, attained a remarkably high level of oral and dental health without compromization of their systemic well-being.

J. Hardie, BDS MSc FRCDC FICDC
Head, Department of Dentistry
Vancouver General Hospital

Toothbrush Design

Dear Editor,

We, consumers and professionals alike, are being bombarded with toothbrush designs. As a result, a frequent topic of conversation among dental hygienists is the pros and cons of various toothbrushes. It occurred to me that dental hygienists should take their "light conversations" to a slightly different level and discuss, in writing, the merits of toothbrush design.

Following is my opinion about the Aquafresh Flex brush. I'm intending it to stimulate discussions among my peers across the country. To that end, I would appreciate it if you could find space in the *Probe* to publish my statement. I am looking for responses to my comment whether they be sent to you and published, or sent to me. My intention is to keep a record of the responses and report to the readership again.

Terry Mitchell, R.D.H.

Below is Ms. Mitchell's opinion of the Aquafresh Flex toothbrush:

Recently dental hygienists across Canada received the new Aquafresh Flex toothbrush. Brush samples were distributed with a product brochure and a research paper.

Although the brush head appeared large for the majority of patients, it was comfortable to use. The long handle does provide a good grip. The bristles were softer than most soft bristles. The flex in the handle was not especially noticeable when brushing, but potentially decreases damage to dentition with long term use.

An analysis of the product research literature indicated the study was done using appropriate research methodology. A weakness with the study was the comparison of the Aquafresh Flex with the Oral B 40 that has a large wide brush head. The study did not identify the head size of the Aquafresh Flex brush. Comparisons drawn between the two brushes about the head size and comfort of the brush in the mouth may be misleading.

In my opinion, the Aquafresh Flex has a place in the armamentarium of the dental hygienist. This is a good brush for patients who 1) have a tendency to be heavy handed when brushing 2) exhibit recession or 3) have teeth/roots that are sensitive. Dental hygienists can relate their success in motivating patients to their individualization of patient education. Given the right individual, the Aquafresh Flex brush is one oral health aid to consider.

CDHA would like to thank Aquafresh for providing all of its members with a poster, pamphlets, and samples of the children's Aquafresh Flex toothbrushes.

Targeted Screening

Dear Editor,

Your scientific editorial in the March/April issue was right on target! The principal messages were clear. First, targeted screening for early detection of many specific diseases is effective and efficient. Second, as health care providers, dental hygienists are both consumer recipients and providers of periodic targeted screening.

As direct service providers dental hygienists are key health educators. Our health education, especially chairside, has traditionally focused on oral health. In more recent years we have included significantly more general health education. This is a clear indication of our understanding and valuing of oral health as an integral component of general health. Examples include the taking of vital signs and discussion of these with the patient, diet consultation on such non-dental issues as the restriction of fats and sodium, and cessation of tobacco use as a general health goal.

In this vital role as health educators dental hygienists can knowledgeably respond to patients' questions and even initiate discussion regarding risk determinants, risk factors, risk markers, and screening procedures. We can provide basic knowledge to patients regarding the screening tools and procedures available and recommended for a variety of diseases.

In a recent extensive investigation of cancer screening, A.M. Horowitz (1992) suggested that health care providers could have significant positive effects on the levels of women's knowledge about gynecologic and colorectal cancer screening procedures. Is this information something that dental hygienists can add to their own knowledge base and share with their patients?

We may not at present be key informants about these and other kinds of screening procedures, but we can certainly advocate for periodic screening, and we can encourage patients to actively seek information to support their self care.

Joanne Clovis, Dip. D.H., B.Ed., M.Sc.
Director, School of D.H.
Dalhousie University

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Researchers Claim Toothpastes Containing Sodium Fluoride More Effective Than Other Toothpastes in the Fight Against Caries

Representatives from the Canadian Dental Hygienists Association and the Canadian Dental Association recently attended a press conference in London, England hosted by Procter & Gamble, at which time the results of a study comparing the effectiveness of sodium fluoride and sodium monofluorophosphate toothpastes were released.

According to a research study conducted by a panel of leading caries researchers drawn from both sides of the Atlantic, toothpastes containing sodium fluoride are significantly more effective for preventing caries than those containing sodium monofluorophosphate. However, the study results noted that this conclusion applies only where the sodium fluoride is formulated into highly compatible toothpaste systems. The data, which was collected during a study conducted by the Fluoride Scientific Advisory

Group (FSAG), indicated that sodium fluoride reduced caries by 6.4% over a 2-3 year period relative to sodium monofluorophosphate (SMFP) toothpastes. Altogether the panel reviewed 44 clinical studies involving over 20,000 patients.

According to a spokesperson for Procter & Gamble, manufacturers of Crest, the 6.4% efficacy difference between the two leading fluorides could translate into much larger differences over ten to twenty years of community use. Conservative models suggest an approximate 20% difference between the fluorides, over fourteen to twenty years.

The study suggests that all fluoride toothpastes are not equal and in fact, those containing sodium fluoride may provide superior dental protection compared with those not incorporating this system. In fact, the research suggests that a child who grows

to maturity using a sodium fluoride toothpaste, could experience a fifth less tooth decay than one who brushes with toothpastes containing sodium monofluorophosphate.

Details released at the press conference say that "Until now most dental professionals believed that all fluoride toothpastes had identical efficacy. However, the results of the Fluoride Scientific Advisory Group's (FASG) analysis have overturned conventional wisdom."

The analysis of the research conducted by the FASG will be published in the July/August issue of Caries Research (The Journal of the European Organization for Caries Research).



CDHA joins the Health Action Lobby (HEAL)

The Canadian Dental Hygienists Association affirmed its commitment to a quality Canadian health care system by joining the Health Action Lobby (HEAL). HEAL is a coalition of national health interests dedicated to ensuring a viable health care system for the future. It was formed in 1991 and believes in open dialogue, public participation and creative solutions. Its founding members are: the Canadian Hospital Association, the Canadian Public Health Association, the Consumers Association of Canada, the Canadian Long Term Care Association, the Canadian Nurses Association, the Canadian Medical Association and the Canadian Psychological Association.

CDHA's Board of Directors is committed to ensuring that Canadians have reasonable access to quality health care at an affordable cost; maintenance of national health care standards (portability, accessibility, comprehensiveness, universality and public administration) and the development of attainable health goals for all Canadians to receive the most appropriate care required. CDHA joins the Canadian Physiotherapy Association, the Canadian Occupational Therapy Association, the Canadian Dietetic Association and the Canadian Association of Speech Language Pathologists as affiliate partners of HEAL.

HEAL's Guiding Principles for Health and Health Care

Health Goals

National and provincial health goals are required. These are prerequisite for the conceptual framework within which resource allocation for the continuum of health care can occur in a responsible and efficient manner.

Continuum of Care

Changing health needs of individuals and society require a broad range of community- and institutionally-based services, an integrated continuum of care, providing coordinated access to a range of types and levels of service should be the model for the Canadian health system. Administrative and financial arrangements should be designed accordingly.

Shared Responsibility for Safeguarding Canada's Health System

Federal and provincial governments share a time-honoured responsibility for safeguarding the five basic criteria of medicare. These criteria are:

- portability of benefits
- universality of population coverage
- access to required services
- comprehensive benefits
- public (non-profit) administration

Consumer Participation in Health Care Decision Making

Health care consumers are partners in health care. As partners, they are involved in decision-making concerning their care, and are jointly responsible with health care providers for health promotion aimed at enhancing the health status of Canadians. It is imperative that health consumers share in policy planning and evaluation, self-help and mutual aid. The health care system should be responsive to the needs of consumers

Individual Rights

While the basis of our health care system is community responsibility, individual rights and participation in the health care environment must be protected and promoted.

Cooperation

Interdisciplinary, intersectoral, intergovernmental cooperative action is required to build consensus around solutions to problems affecting health and health care. Concerted collaborative action is required to address common challenges.

Stability of Funding

Stability of funding is a prerequisite for the provision of quality health services, health planning, research and innovations that improve the effectiveness of care and care delivery.

Efficient and Effective Management

To ensure the long-term availability of resources for the health care system, resources must be managed and allocated in an efficient and effective manner, and the system must provide incentives to do so.

Voluntarism

Voluntarism and community involvement are important components of healthy public policy and healthy self-help and mutual aid efforts is essential.

Professional Self-Regulation and Licensure

Public accountability is effectively discharged through rigorous self-regulation by health professionals. Public participation in self-regulation is valued by health professionals.

CDHA Hires Director of Communications

The Canadian Dental Hygienists Association is proud to announce the recent appointment of Janice Edgar as its Director of Communications. Ms. Edgar is a graduate of Carleton University's School of Journalism (1984) and is no stranger to the dental profession. She coordinated the Canadian Dental Association's Annual Convention from July 1989 until March 1993.

CDHA is pleased to have Janice as a new member of its team. Ms. Edgar will be Managing Editor of *Probe*, CDHA's scientific journal which is a bi-monthly publication, and Editor of *The Explorer*, the Association's internal newsletter. In addition she will assist in the planning and coordination of educational workshops, the annual professional conference and health promotion programs sponsored by the Association.



CDHA Elects New Executive Council

CDHA elected its 1993-94 Executive Council at its Board meeting held in Ottawa in June. Maxine Borowko, President Elect and Marnie Forgay, Vice President join **Fran Richardson Cotton, President** and **Lorraine Boomhour, Immediate Past President** who also sit on the Council.

Maxine Borowko is a resident of Maple Ridge, British Columbia. She received a Certificate in Vocational and Technical Education from the University of Regina. She earned her Diploma in Dental Hygiene and a Diploma in Dental Nursing (Dental Therapy) at the Wascana Institute of Applied Arts and Sciences which is now the Saskatchewan Institute of Applied Science and Technology. Since January 1993 she has been working as a Community Dental Hygienist providing dental hygiene services to persons with mental handicaps through British

Columbia's Ministry of Health. Her duties in this role include developing and implementing a program of dental health services to facilitate the health promotion and dental treatment access needs of adults with mental handicaps living in the community.



MARNIE FORGAY

Margery (Marnie) Forgay is currently a Professor at the School of Dental Hygiene at the University of Manitoba in Winnipeg. She received her Diploma in Dental Hygiene from the Eastman Dental School in Rochester, NY in 1952 and later earned a BA at the University of Saskatchewan (1955), a BEd from the University of Manitoba (1976) and an MA at the University of British Columbia (1980). She has received a number of research grants over the past ten years and has been an active member of CDHA since 1972.



MAXINE BOROWKO

News for Dental Hygienists from Across the Country



ODHA/CDHA Sharing the Load

At a CDHA presidential visit to the Ontario Dental Hygienists' Association's interim board meeting held at the end of April, CDHA President Lorraine Boomhour (right) offered thanks on behalf of the profession to the many contributions put forth by outgoing ODHA President Kathleen Feres Patry (left).

This past May, members of the **Alberta** Dental Hygienist's Association elected Diane Skene-Derksen as their President for the 1993-94 year. Ms. Skene-Derksen graduated from Alberta's Southern Institute of Technology in 1979 as a registered dental assistant and received her diploma in dental hygiene in 1986 from the University of Alberta. She is currently in private practice with a general practitioner who specializes in Periodontics. The ADHA's new president-elect is Carol Brown.

In **Saskatchewan**, the 1994 CDHA Professional Conference Organizing Committee, under the direction of Barb Long and Maureen Bowerman, are gearing up for CDHA's 6th Annual Professional Conference. Be prepared to join your colleagues "next June in Saskatoon" for a conference that will focus on ethical issues surrounding the dental hygiene profession.

In **Manitoba**, Lorraine Glassford was recently elected as president of the Manitoba Dental Hygienists Association for the 1993-94 year. Ms. Glassford graduated in 1988 from the University of Manitoba and works in private practice in Winnipeg.

On May 1st, members of the **Ontario** Dental Hygienists' Association elected Nancy Horky as their president for the 1993-94 year. Nancy is a graduate of Fanshawe College and practises in Waterloo, Ontario.

CFDE/ACFD Strategic Planning Workshop on Educational Standards

CDHA representatives actively participated in an educational standards workshop held in March and co-hosted by the Canadian Fund for Dental Education (CFDE) and the Association of Canadian Faculties of Dentistry (ACFD). During the workshop, CDHA reps shared their views on a variety of dental hygiene concerns with respect to education and national certification. The efforts put forth at the workshop resulted in the development of a strategic plan for educational standards for dental professionals.

In an effort to bring the plan to fruition, CDHA then hosted a workshop in Ottawa in June, at which time the self-definition of the dental hygiene profession and clinical practice standards were reviewed. The results of the workshop are to be incorporated into the deliberations at the ACFD Educators' Workshop that will be held in conjunction with the CDHA Research Conference in Niagara Falls this October.

NFB Offers New Video Series: The 50+ Collection

The National Film Board of Canada has developed a series of videos that will be of interest to caregivers, service providers and older adults. The 50+ Collection includes 20 titles in the areas of Caregiving and Health and Well-Being:

Caregiving

Discussions in Bioethics: A Chronic Problem

Discussions in Bioethics: The Old Person's

Friend

Don't Take My Sunshine Away

A House Divided: Caregiver Stress and Elder

Abuse

Living with Dying

Mr. Nobody

Priory, The Only Home I've Got

Sonia

A Special Letter

When the Day Comes

Health and Well-Being

Age is No Barrier

The Best Time of My Life:

Portraits of Women in Mid-Life

The Impossible Takes a Little

Longer

Is It Hot in Here? A Film About

Menopause

Pills Unlimited

The Power of Time

Reflections on Suffering

Second Debut

Something to Celebrate

You can purchase, rent or preview NFB videos or films through any NFB Video and Film Service. For those living outside areas served by an NFB Video and Film Service, a bilingual toll-free service is available from 10:00 am to 4:00 pm., Monday to Friday. Please use the number for your region:

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Western and Northern Canada	1-800-661-9867



CFDE Announces Program Support for 1993

At its annual general meeting in May, the Canadian Fund for Dental Education (CFDE) Trustees approved \$248,392 in awards to support dental education, research and awareness programs in 1993.

Among the programs benefitting dental hygiene that received support this year are:

- A total of \$9,000 from the Dr. Nicholas A. Mancini, the Dr. W.G. Barrett, and the Dr. Allan Chantler Endowment Funds to assist 11 dental and/or dental hygiene students in financial difficulty.
- A grant of \$6,000 to the 1993 Canadian Dental Hygienists Association "North American Research Conference". Subject areas to be addressed include advances in clinical techniques and technology, disease prevention/health promotion, and theory development and testing.
- The CFDE Murray McDonald Memorial Lecture at the April 1993 ODA/CDA Dental Meeting in Toronto featured a presentation by circumnavigators Fiona McCall and Paul Howard entitled,

"The World was Our Challenge".

- A total of \$31,455 was allocated for teacher/researcher training fellowships including three Warner-Lambert supported fellowships of \$2,500 each. In all, seven dentists, three dental hygiene teachers and one dental assisting teacher received fellowships in 1993. The Henry Thornton Award of \$1,000 offered by Dentsply Canada was awarded to the most meritorious applicant.
- The CFDE/ACFD Summer Teaching/Management Institute was granted \$44,000. The Institute is an intensive eight-day learning experience designed to provide participants with practical teaching methods that can be directly applied in laboratories, seminars, clinics and lectures.

CFDE funding for these and other programs is provided primarily by annual donations from the dental profession, associations, business and industry. The CFDE depends on this support to provide dental educators and researchers with the necessary funding to promote improvements in oral health.

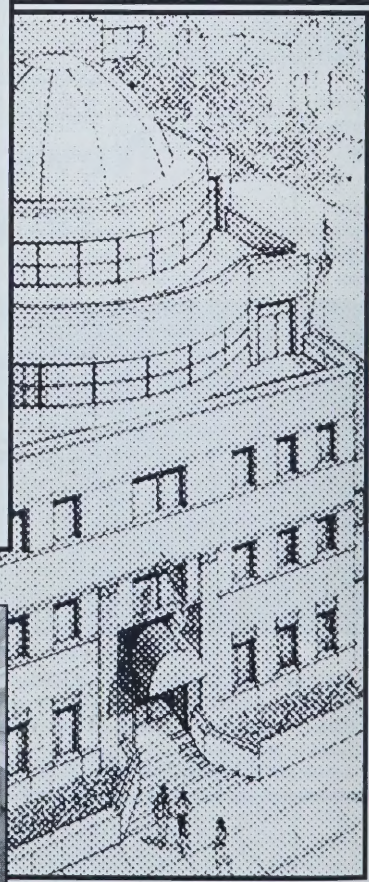
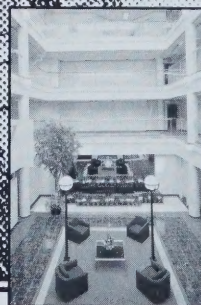
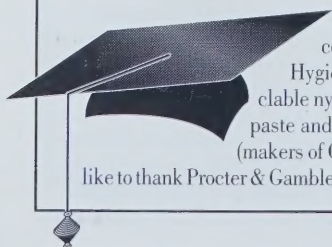
College of Dental Hygiene of Ontario Gearing Up for Business

The College of Dental Hygiene of Ontario recently appointed Linda Strevens as its registrar. The appointment takes effect on August 1st at which time the College will open its doors at 69 Bloor St. East in Toronto. The new college is the licensing body for dental hygienists practicing in Ontario. CDHA extends its congratulations to Linda and the college's Transitional Council and looks forward to a mutually beneficial future together.



CDHA Presents Dental Hygiene Graduates With 'Grad Packs'

More than 700 dental hygiene graduates from across the country received 'graduation packages' from the Canadian Dental Hygienists Association this year. The package consisted of a red recyclable nylon lunch bag containing a portfolio and pen, two tubes of toothpaste and a note of congratulations from CDHA and Procter & Gamble (makers of Crest). Joan Degan, CDHA's Corporate Relations Officer, would like to thank Procter & Gamble on behalf of CDHA for making this program possible.





Development of a Preventive Dental Programme in the Baltic States

By:

Karina Mierins, Dip Dent Hyg, BScD

and

Peter Apse, DDS, Dip Pros, MSc, MRCD(C)

Introduction

Fifty years of a communist-socialist political system has left the former republics of the Soviet Union with a woefully inadequate health care system. As a result, standards for dental health and dental health services are very low. Evidence of rampant dental disease has been accumulated from visits to the Latvian Medical Academy's Stomatological Institute, dental treatment in Canada of visitors from the Baltic States, and epidemiological statistics from Latvia. Why are these central and eastern European countries experiencing rampant dental disease at a time when Canada, USA and other European countries have a dramatically reduced incidence of dental disease?

In this article we will discuss some historical and geographic aspects that have made these countries susceptible to political turmoil which has also adversely affected their health care. We will also look at the prevalence of disease, discuss dental health care and attitudes, and finally we will propose a long term plan as a possible solution to the dilemma of poor dental health.

Historical background

The Baltic States of Latvia, Lithuania, and Estonia are located in the north east corner of Europe, across the Baltic Sea from Sweden and Finland. All three countries share a common history of foreign domination: Germany, Poland, Sweden, and Tsarist Russia have all laid claim to their rolling hills and thousands of lakes. The strategic location of these countries, lying on the ice-free eastern coastline of the Baltic Sea, provided the aggressors with a gateway to the east for Germany and Sweden and to the west for Russia. Between 1918 and 1940 they shared a brief period of independence, but the infamous Molotov-Ribbentrop Pact between Russia and Germany, that divided Europe during World War II, annexed these three tiny countries by the Soviet Union, whose occupation finally came to an end last August, 1991.

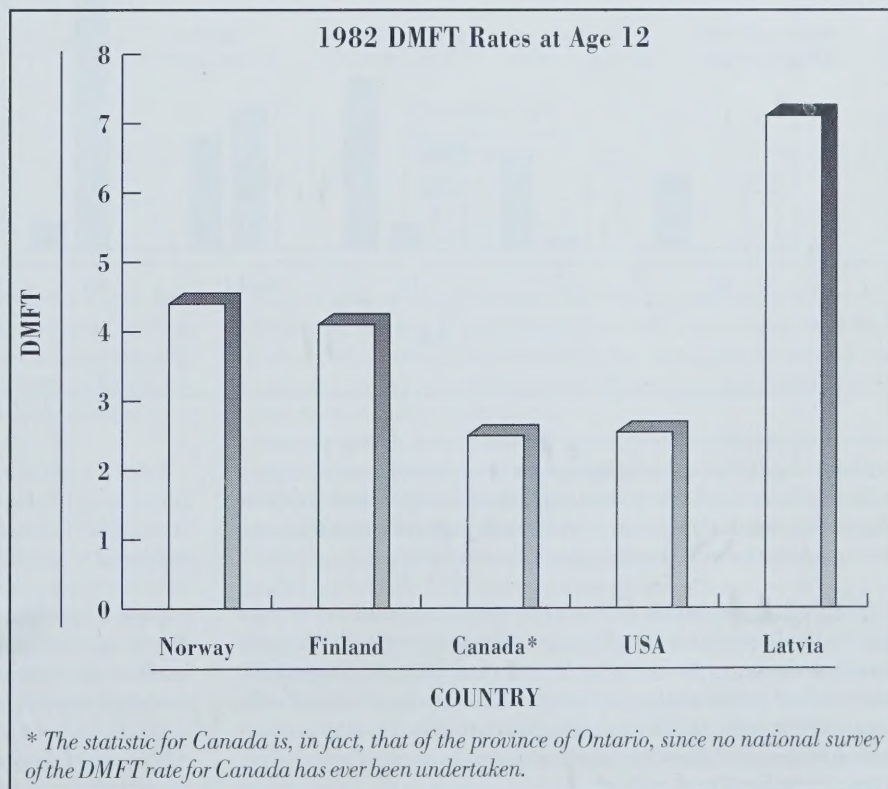
Population data

Lithuania is the largest of the three Baltic Republics, followed by Latvia and Estonia. Latvia has a population of 2.67 million, of which half a million are 14 years of age, or younger. It is the most industrialized of the States, but also the most russified: today, only slightly more than half of the population is ethnic Latvian. The situation dates back to the 1950's, when Russians, assigned to work in Latvia's strategic military bases and relatively modern factories, flooded the country.

During the occupation of the Baltic States by the now former Soviet Union, health care was universally free to all people. The medical and dental health training and services were centrally controlled by

TABLE 1

Table 1 compares the decayed, missing, filled teeth (DMFT) rates of 12 year old children in Norway, Finland, Canada, the USA, and Latvia in 1982. The DMFT rate of 7.1 for Latvian children is significantly higher than Canada's* rate of 2.5.*



Moscow. As a result, the peripheral republics, such as the Baltics, were in a continuous short supply of educational materials, medicines, and health care equipment. The accumulated underfunding resulted in substandard medical and dental health care.

Dental care delivery

In terms of health care delivery, and this system is still in existence today, the ministry of health is responsible to the government, and divides the health care into urban and rural sections. In the cities, dental services are provided through dental polyclinics and dental subdivisions of medical clinics. For example, in Riga, the capital and largest city of Latvia, population: 900,000, there are 3 dental polyclinics and 16 dental

Demographics of dental profession

Looking at the country's demographics, Latvia has 1 dentist per 2,250 people. Although that appears to be a fairly respectable number, these figures include academic and administrative staff. The efficiency of the dentist is greatly reduced by the quality of equipment, much of which is 1950's vintage and dysfunctional. For example, high speed drills most often do not function, and if they do, water coolant is not available. Dental materials are severely lacking both in quantity and quality. Such shortfalls result in poor dental restorations requiring frequent retreatment.

Dentists in Latvia work without assistance of any kind, with procedures slotted into 20 minute appointments, regardless of its nature.

This includes the time required to clean up and prepare for the next patient. Clinical experience suggests that working under such conditions would readily double the required time for any procedure. There are no trained dental assistants or dental hygienists in Latvia, based on the requirements of the former Soviet health care system.

The absence of dental hygienists reflects a total absence of preventive services to the Latvian population. This is common throughout all the former republics of the former Soviet Union and Eastern Europe.

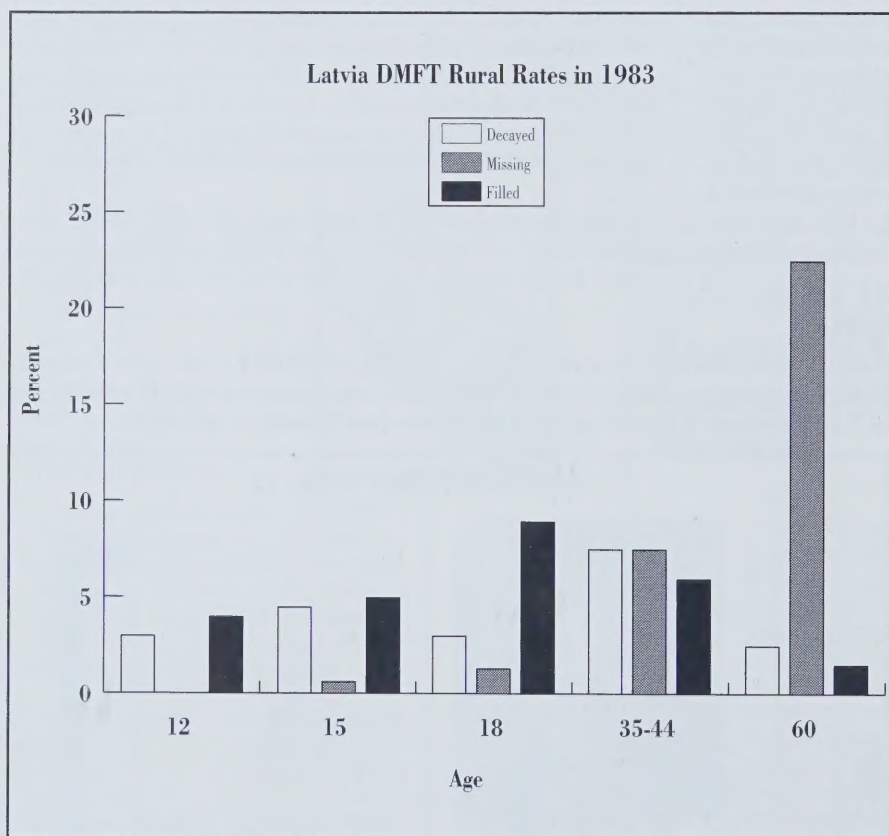
Most operators stand, and four-handed dentistry is a fairly new concept. Instruments and other dental products are left uncovered, and sterilization and disinfection procedures are inadequate, although dry heat sterilizers and autoclaves are available.

Dental health status

The current data we have available to demonstrate the extent of dental disease in the Latvian population is probably a little optimistic, but our clinical observations lead us to believe that the incidence of dental disease is higher than this data demonstrates. In September 1992, the World Health Organization commenced a new assessment of the current dental health status of Latvian people and new data will more accurately reflect the current dental health status.

TABLE 2

Table 2 shows the DMFT data from 1983 of all age groups in rural Latvia. By age 12, the average DMFT rate is 7.1; by age 15, the rate increases to approximately 8.9; and by age 60, most of the teeth have either been extracted or filled.



clinics within medical clinics. In smaller urban areas, dentistry is nested in the medical clinics. Rural areas are serviced through medical clinics with dental divisions, urgent care centres, and through clinics in homes for special care, factories, and schools. From personal communication, one concludes that rural areas are generally underserved.

There are a number of factors that have to be considered when comparing the Baltic States' dentist/population ratios with the Western world. In the former Soviet Union, it was a common practice to magnify the medical personnel/population ratios, since larger ratios were equated with better health care. Although the ratios appear to be equitable with those in Canada, on careful analysis these ratios hide the true nature of the health care system.

Table 1 compares the extent of dental disease in 12 year olds in Latvia, with 12 year olds in Norway, Finland, Canada*, and the United States. DMFT rates of 7 in Latvia are about 2.5 times that of Canadian* residents.

Table 2 shows the 1983 DMFT data of all age groups in rural Latvia. By the age of 12, children have an average of 7.1 teeth with DMFT involvement. By their 15th year, this rises to 8.9 (all permanent dentition) and by age 60, most of the teeth have either been filled or extracted.

Periodontal disease is also rampant in the Baltics. Dental schools do not provide courses in periodontal diseases and consequently no peri-

odontal treatment is provided in practices (see Table 3 — “Periodontal Index of Treatment Needs”). Instruments for removing calculus are rare and poorly constructed; little is known of instrumentation techniques, or the relationship between plaque, calculus and periodontal inflammation. Due to the lack of dental hygienists, preventive services are limited and, in most cases, non-existent. By the age of 12, nearly 50% of Latvian children demonstrate some signs of gingival inflammation.

Contributing factors

1. Dental education

There are several contributing factors that may explain this high incidence of dental disease. For example, the dental curriculum for dental undergraduate students is heavily weighted on medicine, and only 27% of courses taught are actually dentally specific. In addition to this there is a lack of clinical training (due to a limited number of clinical facilities), a severe shortage of dental materials, equipment, instruments, and teaching aids. Furthermore, clinical teaching is frequently accomplished through observation rather than by hands-on work.

2. Dental service

Dental services are limited: dental professionals (or stomatologists, as they are known in the former Soviet Union) are unable to meet the treatment demands of the population. There is, as mentioned earlier, a lack of support staff and pay is poor, reducing motivation.

3. Society

Social attitudes present a problem that is evident in all aspects of society: the lack of motivation to care for oneself; it is a drill-and-fill mentality, complicated by a poor diet, high carbohydrate intake, poor oral hygiene and finally, reluctance to seek dental treatment. There is also a lack of interpersonal respect between dental professional and patient; professionals often don't show empathy for patient's feelings and patients have little confidence in a dental professional whose work often doesn't last for more than a few months.

Preventive programme

Due to the economic situation that exists in the Baltic States today, the development of a preventive dental health care programme is the most cost-effective and biologically sound way of improving, in the long term, the dental health status of the Latvian people. At the present time, there is almost no preventive education for dentists or dental students, and consequently almost none for the people. Preventive dental products are lacking: toothpaste with fluoride is difficult to find or expensive, tooth brushes are large and have hard bristles, dental floss or other types of interdental cleaning are almost non-existent.

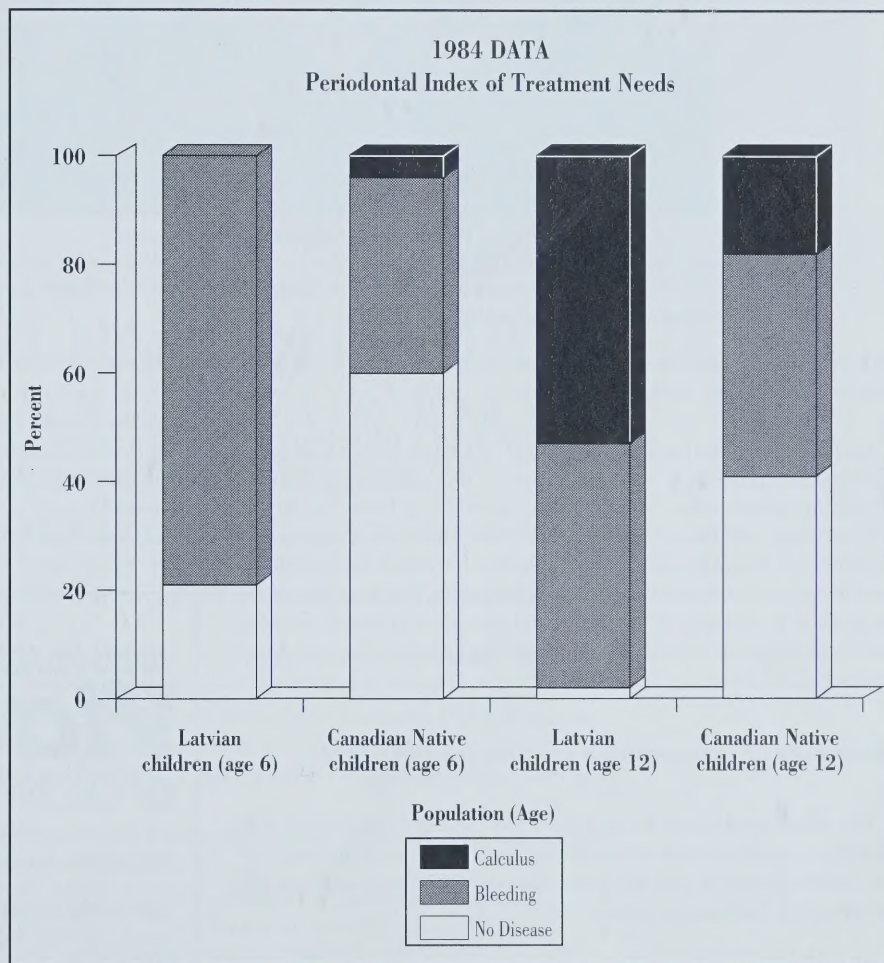
TABLE 3

Table 3 looks at the “Periodontal Index of Treatment Needs” (calculus, bleeding, no disease) for Latvian children at ages 6 and 12 and compares this with Canadian native children at ages 6 and 12.

By age 6, almost 80% of Latvian children show signs of gingival inflammation (bleeding) compared with less than 40% for Canadian native children at the same age.

At age 12, more than 50% of Latvian children have calculus compared with approximately 20% for Canadian native children.

This data, from 1984, shows that Latvian children have an earlier and higher incidence of gingival inflammation than Canadian native children.



Two programmes in preventive dentistry are required to effectively incorporate prevention at all levels of society: a programme for dental students which would be presented at the undergraduate level and a programme for training preventive dental assistants and dental hygienists at the community college level.

In order to initiate a preventive programme in Latvia, we began by teaching dental hygiene techniques to the staff of the dental school in Latvia. As a pilot project, four medical nurses with dental experience were taught basic preventive dental hygiene techniques during our visits, and have, since 1990, been providing these services on an ongoing basis in two locations in Riga. This convinced the academic staff that this was the only approach that seemed realistic at this point in time. We sought funds to support educational endeavors for the development of both dental assisting and dental hygiene programmes. The Canadian Government's "Task Force on Central and Eastern Europe" has supported our efforts with a sizable grant that will enable us to send dental professionals from Canada to teach the staff and students over the next



Dental Team to Latvia

Left to Right: George Sandor (oral/maxillofacial surgeon; plastic surgeon); Karina Mierins (dental hygienist); Janis Slapins (Director of the Health Centre "Jaundubulti"); Silvija Janusonis (general practitioner); Peter Apse (prosthodontist).

two years. These courses will be based in the Riga First Medical School, a community college equivalent.

Course curriculum has been developed by George Brown College in Toronto and tailored to meet the needs of the Latvian population. Teaching modules developed by the University of Kentucky in the United States will be provided to assist in the education process. Just recently, the Royal Dental College in Aarhus, Denmark sent a delegation to Latvia to offer assistance in dental auxiliary training. They hope to assist in the training of Latvian dental educators in dental assisting and dental hygiene as well as co-ordinate the Scandinavian countries' assistance to Latvia.

An ounce of prevention is worth a pound of cure

Our programmes have the support of the Latvian Minister of Health and their intention is to steer the graduates of both courses into the public health system to provide preventive dental education to all age groups of the Latvian population.

Our goal is to provide sufficient support to enable Latvia to become self sufficient in the education of preventive dental health professionals within a five year period. This programme, being the first of its kind in this area of the world, could serve as a model for other programmes in the transfer of educational, technological, and medical expertise in the other two Baltic States and other countries in Eastern and Central Europe, all of whom share the same high incidence of dental disease. Although this programme is in its developing stages and problems are surfacing with time, we are optimistic that this pilot project will be helpful in leading the way to the renewal of dental health care in these newly emerging democracies of Central and Eastern Europe.

This paper was presented by Ms. Mierins at the 12th International Symposium on Dental Hygiene in The Hague, Netherlands, July, 1992.

The authors gratefully acknowledge the Government of Canada's Task Force on Central and Eastern Europe and the Latvia Relief and Development Fund for their financial support.

About the authors:

Karina Mierins is a public health dental hygienist with the Region of Peel Health Department in Ontario; Peter Apse is an assistant professor of prosthodontics who recently left his position at the University of Toronto to teach at the Latvian Medical Academy's Stomatological Institute in Riga, Latvia.

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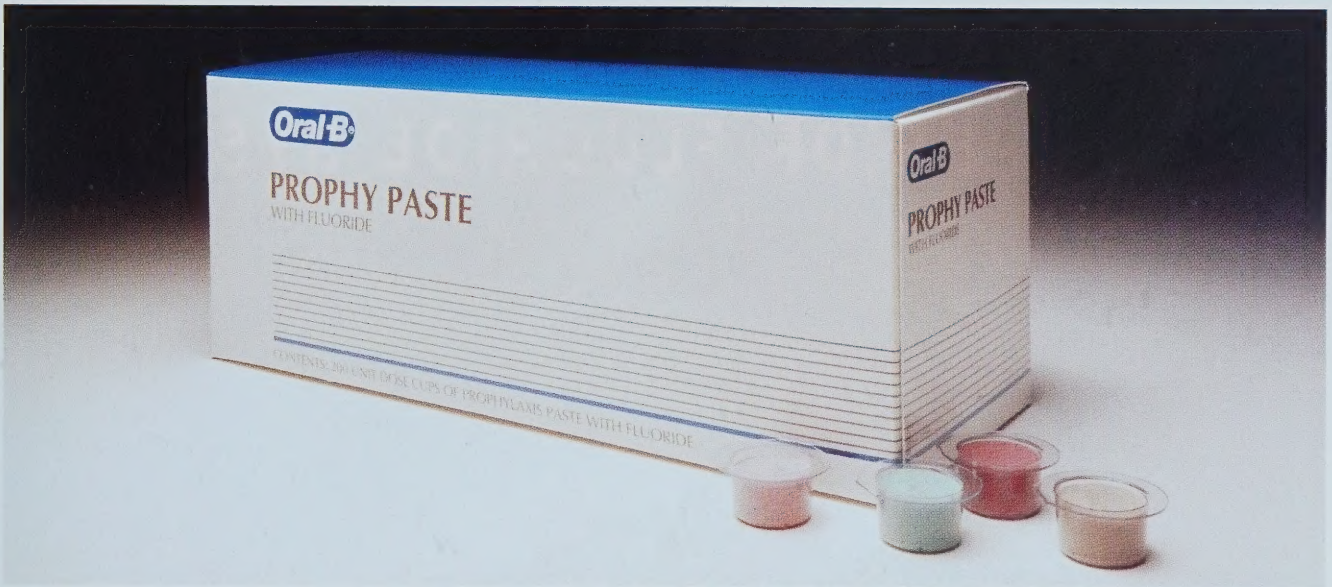
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References 1. Stookey GK et al. *Caries Research*, June 1993.
Applies for equal total fluoride levels versus SMFP.
2. Procter & Gamble, data on file based on mathematical model In:
Kingman A. *Caries Research* 1993; in press.
P A A B





By:
Janice Williams, RDH

Economic Study of a Two Chair Hygiene System

Dental hygiene services play a major role in the economics of a dental practice. To survive the financial challenges of the '90s, an office goal should be to improve and increase hygiene productivity. The purpose of this study is to determine the economic value of a "Two Chair Hygiene System" in a dental office.

The study was conducted in two separate, three month periods. In one three month period, data was collected for one hygienist working one chair. This was called the "One Chair Hygiene System". During the second three month period, data was collected for one hygienist working two chairs with an assistant; called the "Two Chair Hygiene System".

The results demonstrate that a "Two Chair Hygiene System" is of economic benefit to a dental practice. The findings show an increase in the hourly hygiene production, the hourly hygiene salary and in the number of patients treated per hour. There was a decrease in the amount of hygienist time required per appointment due to efficient delegation to the assistant. The total office salary cost remained constant.

The results of the study suggest a "Two Chair Hygiene System" is an efficient method of delivering hygiene services.

I. Introduction

The dental practice of the '90s is under financial pressure to be more efficient in the delivery of dental health services. One solution is to delegate and assign to responsible staff, such functions as scheduling, accounts, office management, assisting functions and hygiene services¹.

Since the dental hygienist is a major provider of dental care, an office goal should be to improve and increase hygiene productivity. There have been many articles written relating to the topic of increasing hygiene profits. They have discussed implementing periodontal maintenance programs², utilizing an efficient recall system³, assessing the patient's required treatment time⁴ and relating hygiene salary to hygiene production⁵.

Another possible solution is for the hygienist to delegate duties. This will allow the hygienist to perform skilled hygiene duties while other staff members are responsible for such duties as x-ray developing, charts, room disinfecting and instrument sterilization.

The purpose of this study is to determine the economic value of a "Two Chair Hygiene System" in a dental practice.

II. Study Design

The study was conducted in two separate, three month periods, with the same hygienist working both periods. The one chair data was collected during March, April and May 1989. This period is referred to as the "One Chair Hygiene System". The hygienist working two chairs with a hygiene assistant data was collected during August, September and October 1989. This period is referred to as the "Two Chair Hygiene System".

The dental office setting was a computerized, preventive group practice, with a large patient volume. For this study there were two fully equipped hygiene operatories available. The types of hygiene services rendered were: (1) three, six and nine month adult recalls; (2) pedo

Figure 1
45 Minute, Two Chair Schedule

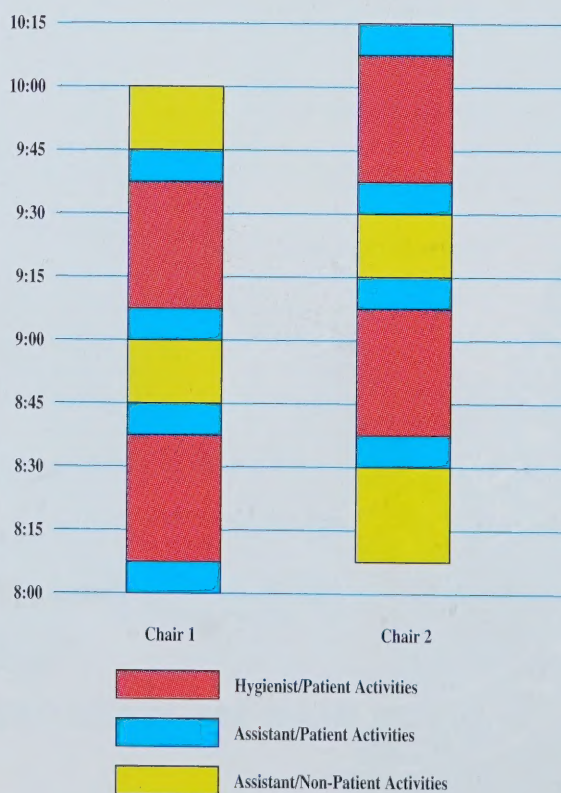


Table 1
Duties of the Dental Hygiene Assistant

- greet and dismiss patients
- provide friendly patient conversation
- update all patient information on their charts and in the computer
- record on the chart any necessary information ie. patient history, treatment required, treatment received, third party coverage
- make computer entries and print insurance form and receipt
- reschedule the patients
- instrument and room set up for each patient
- stock room supplies
- sterilize instruments and follow proper room asepsis
- develop and mount dental x-rays
- clean and maintain automatic x-ray processor
- maintenance of hygiene room equipment and handpieces

recalls; (3) new patient visits; (4) necessary x-rays; (5) periodontal assessments and scalings. Although no attempt was made to balance the types of patient workload, they were similar during the two study periods. The office staff responsible for patient scheduling were very committed in keeping the failed and cancelled appointments to a minimum.

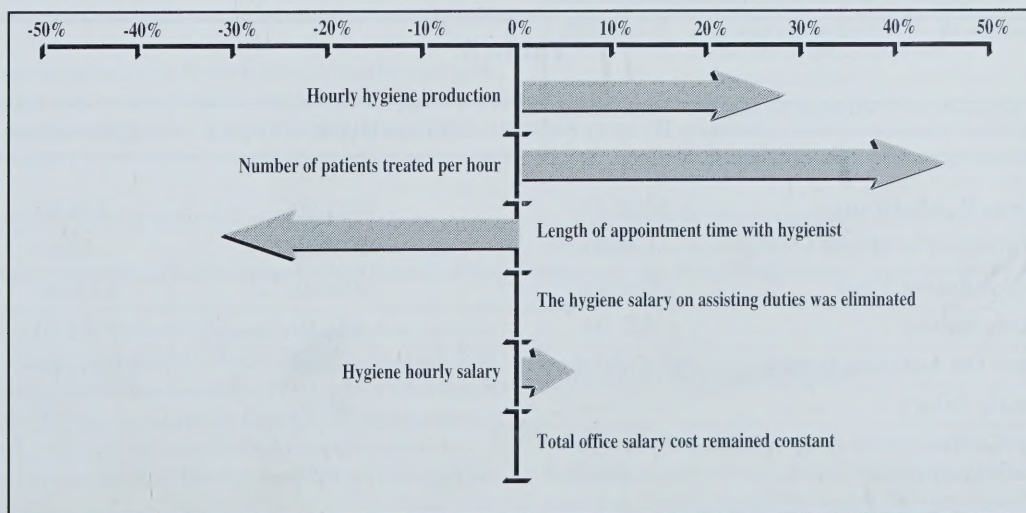
In the "Two Chair Hygiene System" the forty five minute recall patient was scheduled for thirty minutes, although each spent forty five minutes in the chair. In this system the hygiene time required was approximately thirty minutes. When the hygienist is completed, the assistant remains to address approximately another fifteen minutes of duties. The hygienist is already treating the next patient. An example of the hygienist, assistant schedule for the forty five minute recall patient is illustrated in Figure 1. The hygiene assistant was hired to perform the duties listed in Table 1. These duties were performed by the hygienist in the "One Chair Hygiene System".

The following categories were used to collect study data:

A. Gross Production	the total hygiene production for the three month period
B. Hygiene Hours on Hygiene Duties	number of hours the hygienist worked hygiene duties
Hygiene Hours on Assisting Duties	number of hours the hygienist worked assistant duties
Total Hygiene Hours	the total hours worked by the hygienist for the three month period
C. Assistant Hours Worked	the total hours worked by the assistant on assisting duties for the three month period
D. Hourly Production	gross production divided by the total hygiene hours worked
E. Number of Appointments	number of patients treated for the three month period
F. Number of Appointments Per Hour	number of patients treated per hour
G. Length of Appointment Time	amount of time hygienist treated patient
H. Hygiene Salary on Hygiene Duties	income when working hygiene duties
Hygiene Salary on Assisting Duties	income when working assistant duties
Total Hygiene Salary	total income paid for three month period
I. Assistant Salary	total income paid for three month period
J. Hygiene Hourly Salary	hygiene income per hour
K. Assistant Hourly Salary	assistant income per hour
L. Salary Cost Percentage Of Production	office salary expense (hygienist and assistant) as related to production

III. Study Results

The data collected is displayed in Table 2 and a data comparison is shown in Table 3. The following observations were made when the results were displayed in percentage form.



1. Hourly hygiene production increased by 28%
2. Number of patients treated per hour increased by 45%
3. Length of appointment time with hygienist decreased by 31%
4. The hygiene salary on assisting duties was eliminated
5. Hygiene hourly salary increased by 5.6%
6. Total office salary remained constant

IV. Conclusion and Discussion

The results demonstrate that the "Two Chair Hygiene System" is of economic benefit to the dental practice. It emphasizes the importance of delegating duties to other personnel to increase productivity. Duties such as sterilization, room supplies, developing and mounting x-rays, computer work and charting are completed by an assistant. This eliminates paying hygiene salary when assisting tasks are performed. The findings showed an increase in the hourly hygiene production, the hourly hygiene salary and in the number of patients treated per hour. There was a decrease in the length of hygienist time required per appointment. The total office salary cost remained constant at 26% of production.

As the hygienist working in the "Two Chair Hygiene System", I required a few weeks to adjust to my new routine. Also, after a short time I became physically comfortable with the increased patient workload. By utilizing the "Two Chair Hygiene System", I was able to share my scheduled workload with an assistant. This allowed for full concentration on my hygiene duties.

During this study there was no change made in the quality level of patient care.

In addition to the study results, other factors that may need to be considered include:

- a. availability of hygiene rooms and equipment
- b. volume of hygiene patients
- c. level of office staff team work
- d. a hygienist who is mature, flexible and clinically sound

Table 2

CATEGORY	1 CHAIR HYGIENE SYSTEM	2 CHAIR HYGIENE SYSTEM
Gross Production	\$35,933.00	\$52,005.00
Hygienist:		
Hours on Hygiene Duties	243.0	395.5
Hours on Assisting Duties	108.0	—
Total Hygiene Hours	351.0	395.5
Assistant:		
Hours on Assisting Duties	—	395.5
Hourly Production	\$102.37	\$131.49
Number of Patients	502	819
Number of Patients Per Hour	1.43	2.06
Length of Appointment Time	42 mins	29 mins
Hygienist:		
Salary on Hygiene Duties	\$6,542.10	\$11,271.00
Salary on Assisting Duties	\$2,934.90	—
Total Hygiene Salary	\$9,477.00	\$11,271.00
Assistant Salary	—	\$2,373.00
Hygiene Hourly Salary	\$27.00	\$28.50
Assistant Hourly Salary	—	\$6.00
Total Salary Cost as Percentage of Production	26%	26%

V. Acknowledgement

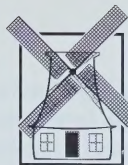
This study was conducted at Niagara Dental Group, Niagara Falls, Ontario, Canada. The assistance of Tracy Pasco and the support from Dr. Tillman Kershaw and the efficient dental team is appreciated.

References:

1. Quinn, J. Delegate key functions to your staff for productivity. *Dental Management* 23(6): 34-35, 38, 40, 42, 1983.
2. Pixley, B., Rossi, B. Seven steps to better perio care in general practice. *Dental Management* 28(4): 33-38, 1988.
3. Dreyer, R. How your hygienist can increase your profits. *Dental Management* 26(9): 46-49, 1986.
4. Schulman, B. Improve hygiene productivity. *Dental Economics* 77(10): 23-24, 1987.
5. Wagman, D. Hygiene headaches? A better way to pay your RDH. *Dental Management* 27(3): 58-59, 1987.

Table 3

CATEGORY	1 CHAIR HYGIENE SYSTEM	2 CHAIR HYGIENE SYSTEM	COMPARISON	UNITS %
Hourly Hygiene Production	\$102.37	\$131.49	\$29.12	+28%
Number of Patients Per Hour	1.43/hr	2.07/hr	.6/hr	+45%
Length of Appointment Time	42 mins	29 mins	13 mins	-31%
Hygiene Hourly Salary	\$27.00	\$28.50	\$1.50	+5.6%
Hygiene Salary On Assisting Duties	\$2,934.00	—	\$2,934.00	-100%
Assistant Hourly Salary	—	\$6.00	0	0%
Office Salary Cost as Percentage of Production	26%	26%	0	0%



A Workshop Approach to Enhancing the Quality of Dental Hygiene Care

*Presented at the 12th International Symposium on Dental Hygiene
The Hague, Netherlands, July 2, 1992*

By:

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Introduction

Quality of care is an issue affecting all health care professionals at this time. An essential part of quality care is the definition of practice standards and their application. In Canada the problem was seen as not merely to develop practice standards, but to make sure they reflected the standards of dental hygienists in clinical practices, make them widely known to practicing dental hygienists throughout Canada, and to assist in their application.

The Canadian quality assurance workshops provide a structured process for dental hygienists to assess their own clinical practices against practice standards developed and published by Health and Welfare Canada (a department of the federal government).

Development of the Clinical Practice Standards

The development of the practice standards document represents a unique achievement in the area of quality assurance for dental hygienists. In 1983 Health and Welfare Canada, through the Working Group on the Practice of Dental Hygiene which it had created in 1981, initiated a project to develop clinical practice standards. The project was managed by an Advisory Committee which included dental hygienists, dentists and research methodologists. The project researcher was a dental hygienist/management consultant.

The Advisory Committee wanted to develop clinical practice standards which had a high degree of content validity and practical application. Therefore, practising dental hygienists were involved in developing and validating the standards.

The development process included the following steps:

1. A literature review to identify and select an appropriate framework for the standards.
2. Holding a workshop in 1985 with 12 dental hygienists from the four regions of Canada (Atlantic, Quebec, Ontario, West) to develop a draft statement of the standards. The dental hygienists who were selected for the workshop had been nominated by their provincial associations and represented a wide range of types of education and experience.
3. Refinement of the standards by the Advisory Committee and the Working Group.

4. Developing detailed research protocols and surveying a random sample of Canadian dental hygienists to establish content validity in 1987.
5. Final revision of the standards using the survey results and recommendations from the Advisory Committee and Working Group.

The practice standards were organized into three major categories: structure, process and outcome — the key dimensions of the Donabedian model of health care evaluations.¹

STRUCTURE — the physical facilities, records and management practices which enable the dental hygienist to provide care — the employment situation			
PROCESS — the clinical and educational procedures performed by the dental hygienist — the process of dental hygiene care has four phases:			
ASSESSMENT gathering information	PLANNING goal setting	IMPLEMENTATION performing dental hygiene procedures	EVALUATION measuring the outcomes/results of dental hygiene care
OUTCOMES — the results of dental hygiene care			

Within each of the three dimensions there were several criteria and related standards. The Bloch definitions² applied.

CRITERIA — variables believed or known to be relevant indications of the quality of care	
STANDARDS — desired and achievable levels of ranges of performance with which actual performance is compared	

"The dental hygienist develops a plan for a patient's dental health education" is an example of a process (planning) criterion to which the standard "by identifying desired goals for dental health education" applies.

C.D.H.A. Enabling Role

When the Practice Standards document was published in 1988, a copy was mailed to every dental hygienist registered in Canada. The Canadian Dental Hygienists Association has identified quality assur-

ance as one of its major goals. It was concerned that the Practice Standards, once read, might lie neglected on a shelf. In order to publicize the Practice Standards, the Association published several articles in its Journal "Probe" encouraging dental hygienists to use the Practice Standards. Its major initiative, however, was to develop, pilot test, implement and evaluate workshop materials which would then be made available to dental hygiene organizations and continuing education providers throughout Canada.

The workshop materials were developed and pilot-tested in Winnipeg, and then revised. Then, six revised workshops were held in various locations across Canada. Three months following the workshops, an evaluation was conducted by contacting the individual participants. Finally, the workshop materials were duplicated and made available at dental hygiene organizations throughout Canada.

Taking Steps Toward Ensuring Quality of Dental Hygiene Care: A CDHA Quality Assurance Workshop

Workshops: Content and Process

Promotional Materials

To ensure that participants were informed about the content and purpose of the workshop, the promotional materials (brochure) clearly outlined the course objectives and the responsibilities of the learner. Specifically, the learners would be required to:

1. complete the Clinical Practice Standards Self-Assessment Tool (prior to the workshop)
2. develop and carry out a self-directed learning project

The Self-Assessment Process

The self-assessment tool closely followed the existing *Clinical Practice Standards for Dental Hygienists in Canada*, both using the **Structure-Process-Outcome** model. For each standard, the dental hygienists indicated whether they:

1. met the standard: YES
2. needed to improve upon the standard or
3. did not meet the standard: NO

Once the standards requiring improvement were identified, they were ranked until a top priority was selected as the workshop focus.

Developing the Self-Directed Learning Project

The development of a personal "**Action Plan**" or self-directed learning project provided the structure and organization required to address their top priority learning need.

Using the self-directed method allowed the dental hygienists to *make their own decisions* regarding when, how and what they would learn, thus, learning something *useful and relevant* to them. After completing this self-designed project, these newly acquired strategies and skills could then be applied to future professional learning projects.

This self-directed/self-designed process was critical to developing each individual's motivation — a basic requirement for stimulating them to make the effort to learn and change.

These steps not only allowed dental hygienists to leave with a written **Action Plan** but with some strategies that would help them to successfully complete their learning project.

THE FOUR STEPS OF THE SELF-DIRECTED LEARNING PROJECT

1. Completing the Self-Assessment (prior to workshop)

- a. "In what areas do I need to make changes and/or improvements"
 - *identify your learning needs/target areas*

2. Developing the Action Plan

- a. "I need to change and/or improve"
 - *select your top priority need for this project, not too broad, not too narrow*
- b. "Tackling this learning project will enable me to..."
 - *determine your broad goal statement*
- c. "When I have completed this learning project, I will be able to..."
 - *determine your specific objectives*
- d. "How will I go about doing this project — the specifics"
 - *determine your strategies, resources and time frame (encouraged using a variety of non-traditional strategies: Study Clubs, mentoring, office in-services, observing other dental hygienists, accessing library resources, auditing courses, research, writing, teaching, etc.)*

3. Carrying out the Action Plan

- a. "What may prevent me from reaching my goals?"
 - *identify your potential barriers (e.g. no time, limited available resources, employer/co-workers need convincing)*
- b. "How can I overcome some of these barriers?"
 - *identify your possible solutions (e.g. form a collegial support group, include professional development time in your schedule, be well prepared for discussions with your employer/co-workers)*

4. Monitoring and Evaluating Progress

- a. "How can I keep myself organized and on schedule?"
 - *determine monitoring strategies (e.g. keep a "log" (diary), regularly "check in" with mentor/colleagues/peer resource group)*
- b. "Have I reached my goal?"
 - *determine evaluation strategies*

Workshop Methodology

All the dental hygienists were able to complete each of these Action Plan steps because:

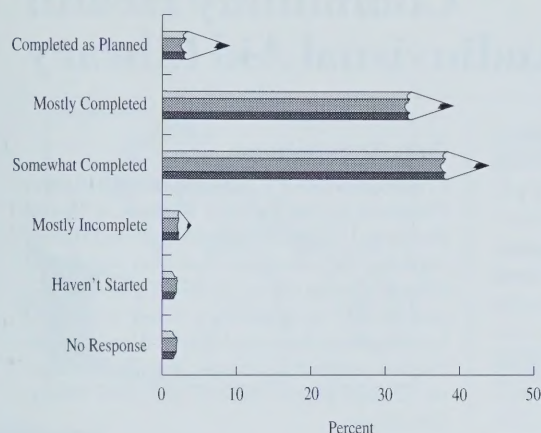
1. Everyone took one step at a time.
2. Each step was first explained and modeled by the facilitator.
3. Each step was further explored through group and pair activities. These actively involved the participants, encouraged group problem solving, and generated a broad range of ideas.
4. After each participant completed a step, peers and the facilitator provided feedback.

Evaluation Procedures

During the initial planning of the project it was determined that an evaluation phase would be necessary. Two stages of evaluation were employed: one immediately following the workshop and the other 3 months after the workshop.

The recurring "themes" on the participant evaluations immediately following the workshops included:

In relation to the goal on the Action Plan, would you say that you have...



- Participants found the Self-Assessment Tool to be clear and useful
- They were able to develop a personal Action Plan
- They enjoyed the opportunity of sharing ideas with fellow dental hygienists
- They felt they had increased their ability to make professional changes.

The main objective for the "follow-up evaluation" was to measure the extent to which the workshops assisted the adoption of the Clinical Practice Standards.

The method of data collection was a semi-structured interview. Each participant, whose Action Plan was received was telephoned approximately 3 months later by a single interviewer. A frequency count and cross-tabulations were done.

	Frequency
Total number of Action Plans received:	93
Number of participants contacted:	78
Number of participants not contacted:	15
Number of Action Plans not available:	1

The semi-structured nature of the questions produced a wide diversity of responses which were tabulated into response categories and some interesting overall trends emerged.

Approximately one-half of the participants completed or mostly completed their action plans. When the category of "somewhat" completed is taken into consideration, 93% of participants were able to make some changes in their practice as a result of attending the workshops.

Although success or lack of success in completing the Action Plan could not be related to any specific variable, time available during the day to work on the Action Plan was the one barrier identified most frequently.

"What barriers got in the way of completing your Action Plan?"

-lack of time during the day	46%
-lack of support from employing dentist	18%
-lack of support from co-workers	8%
-lack of time during patient appointments	6%
-no follow through on Action Plan	6%

Analysis of the Action Plans in relation to Clinical Practice Standards identified those criteria from the Clinical Practice Standards most frequently identified by participants as areas in which they wanted to make changes in their clinical practice (a maximum of 3 criteria were identified for each participant). Planners of continuing education courses may be interested to note that the criteria related to the planning phase of dental hygiene care as identified over 50% of the time.

The five most frequently identified criteria from the clinical practice standards were:

- The dental hygienist maintains ongoing records in order to assess the oral health status of a patient. 39%
- The dental hygienist develops a plan for the patient's dental health education. 30%
- The dental hygienist develops a plan for a patient's hygiene care consistent with the overall plan of dental care. 23%
- The employment situation provides permanent patient records required for effectiveness and continuity in dental hygiene care. 23%
- Outcomes are evaluated in terms of the goals specified in the dental hygiene plan of care. 21%

Individual responses which give an impression of the significance of the workshop include:

- "made me proud to be a part of an organization looking at practice standards"
- "motivated my dentist to learn about the practice standards"
- "helped me establish a relationship with another hygienist where we could be role models for each other".

Conclusion

The Clinical Practice Standards Workshops had the desired outcome of assisting participants to make changes in their dental hygiene practice. Participants were able to identify an aspect of their practice which they wished to change and outline a plan of action. The workshop also made participants aware of the Clinical Practice Standards and provided them with an organized approach to integrate the standards into their daily practice.

Workshop materials have been duplicated and are on loan to any dental hygienist or dental continuing education provider through the Canadian Dental Hygienists Association. The rental cost is nominal and may be waived under special circumstances. Ideally, the number of workshop participants should not exceed sixteen. Workshop materials include a facilitator's handbook, making it easy for any experienced facilitator to conduct the workshop. If assistance in locating a facilitator is desired or to preview workshop materials, contact the C.D.H.A. office, 1018 Merivale Rd., Ste 201, Ottawa, ON K1Z 6A5.

References

- 1 Donabedian, A; "Evaluating the Quality of Medical Care" Millbank Memorial Fund Quarterly, Volume 44, Part 2, 166-203, 1966.
- 2 Bloch, D. "Criteria, standards and norms — crucial terms in quality assurance" Journal of Nursing Administration, September 20-30, 1977.

Seniors

Packages

- I "Oral Health in the Elderly: A Workshop Curriculum and Teacher's Guide" (2 available)
- II "Oral Health Education for the Elderly...A New Preventive Dental Care Program" (1 available)
- III "Training and Motivational Materials in Geriatric Dentistry" (1 available)

Manuals

- IV "Geriatric Oral Health: A Training Manual for Long Term Care Facilities" (2 available)
- V "Assessing the Aging Mouth" (1 available)

Slide-Script Set

- VI "Senior Smiles" (2 available)

Videotapes

- VII "12-Minute Videotape (VHS) for the Elderly" (In French only — 2 available)
- VIII "Options: Dental Health in Later Years" (2 available)
- IX "The Senior Smile" (2 available)
- X "Oral Health and the Elderly" (1 VHS available)

Special Needs

Slide-Script Set

- I "Prevention and Treatment Considerations for the Dental Patient with Special Needs"

Children

Videotapes

- I "Toothbrushing with Charlie Brown" (2 available)
- II "It's Dental Flossophy, Charlie Brown" (2 available)
- III "The Barnyard Snacker" (2 available)
- IV "The Haunted Mouth" (2 available)

Other

Videotapes

- I "Fluoride — The Magnificent Mineral" (2 available)
- II "Fantastic Fluoride" (2 available)
- III "Oral Problems of Patients with AIDS and HIV" (1 set available in English/ 1 set available in French)
 - Part I a) Dr. Norbert Gillmore
b) Mr. Rick Hatt
 - Part II "The Global Occurrence of AIDS"
 - Part III "HIV Associated Periodontal Disease"

New Acquisitions

Prescription for Periodontal Health (12 min.) Presented by the National Institute of Dental Research, U.S. Department of Health and Human Services. This video describes what periodontal disease is, what causes it, how it progresses in severity and the importance of oral hygiene to remove dental plaque and regular dental visits to diagnose and treat this disease. This film is intended for high school students and older adults. (2 available)

More Than Just a Pretty Smile (10 min.) Presented by the American Dental Hygienists Association. This colour presentation can be viewed at meetings and used as a recruitment tool. The program features dental hygienists telling of the satisfactions of their work. Special emphasis is given to volunteer activities used to promote the first National Dental Hygiene Week in 1985. This tape was originally shown at the 1986 American Dental Hygienists Association's Annual Session as a slide presentation, and because of popular demand it was converted to video-cassette format. (1 available)

Dentistry Update (30 min.) Presented by the American Dental Association and Oral-B. Topics covered include: periodontal diagnosis; esthetic dentistry of vital teeth and dentistry & AIDS (1 available)



Canadian Dental Hygienists Association Community Health Audiovisual Aid Library Order Form

Notes to the Borrower:

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- 2) All materials obtained through the CDHA Audio Visual Library are on a **loan basis only.** Should you wish to inquire about the purchase of these materials, please do so through the original source.
- 3) A **Visa number must be provided** for each individual information package request. This would be used to cover a **\$10.00 shipping and handling fee** accompanying each package.
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- 5) Should you have any suggestions for library acquisition or you would like to place your order by phone please contact: Donna Awrey, 1013 Merivale Rd. Suite #201, Ottawa, Ontario, K1Z 6A5 or by phone at 1-800-267-5235.

Print Name/Contact: _____ IDNO.# _____

Address: _____

Phone#: (Home) _____ (Office) _____

Visa #: _____ Expiry Date: _____

Cardholder Name: _____

REQUESTED ITEM:

Title: _____

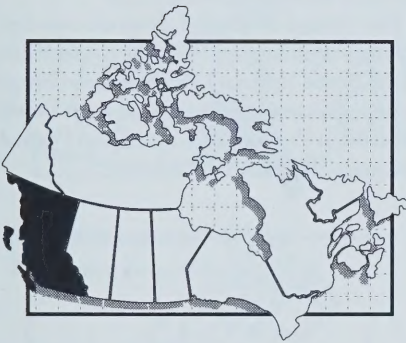
Age Group: _____ Number# _____

Required date for receipt of material: _____

Purpose/Function: _____

Signature as to the understanding of the contract above: _____

Note: It is important that the complete order form, with the contract wording, is returned.



Camosun College Victoria, British Columbia

The Dental Hygiene Program at Camosun College is Canada's newest dental hygiene program and in May it underwent an evaluation to determine its initial accreditation status. The program's third dental hygiene class of 23 students graduated in June.

The faculty are developing externship programs for students in practice and alternative dental care settings. As the dental hygiene curriculum was developed to foster problem solving and critical thinking skills, the externships will be designed not only to educate students about different settings for dental hygiene care, but to develop community awareness of the need for dental hygiene care and ultimately to develop new positions for dental hygienists.

As a result of the new contract recently signed by the Camosun College Faculty Association and the College Board of Governors, continuing faculty are eligible for up to 42 paid days of organizational, instructional and professional development each year. This will allow the dental hygiene faculty to work on various special projects including an admissions study, and the integration of the Dental Assistant and Dental Hygiene Programs. In addition, staff will have an opportunity to plan continuing education programs, develop a plan for computerization of records and computer-aided instruction, and review the integration of dental sciences courses into the program. Other projects planned include the completion of clinic, faculty and student manuals.

Vancouver Community College Program of Dental Hygiene Vancouver, British Columbia

A major focus of this year's efforts revolved around the revision of our curriculum which is organized into a competency profile including the related knowledge section of each aspect of dental hygiene practice. In previous revisions, when the competencies were organized into the assess, plan, implement, and evaluate aspects of the process care model, it became evident

that some areas did not reflect the comprehensive nature of our program content. In response to this, the following competencies have been expanded into four separate ones:

- Community Dental Health Service
- Professional Communications
- Promoting Wellness

To facilitate the problem solving aspects of clinical dental hygiene, a new competency in Decision Making was also introduced into the curriculum document. This competency is based on various diagnostic and problem solving models from the health professions, but has been adapted to reflect the dental hygiene practice environment.

This being our second year working with "Performance Logic" concepts of balanced posture, we have integrated this individualized approach into our competency profile which previously reflected the more standard approach to balanced positioning.

Our Music Therapist has developed an interview sheet to allow clinicians to assist patients in the selection of music for the dental environment. A series of tapes have been developed to provide individualized music for our patients.

Faculty and students are involved in the collection of saliva samples to assess levels of neutrophilases in the gingival crevicular fluid via an oral rinse saliva test. This is being done in collaboration with the Department of Oral Biology at the University of British Columbia.

Two students and a faculty member, Ginny Cathcart, took part in an Edmonton exchange with the program at the University of Alberta, or the West Edmonton Mall. And last, but not least, we underwent an accreditation review in May.

College of New Caledonia Division of Dental Studies Prince George, British Columbia

In June, the College of New Caledonia (CNC) graduated 20 dental hygiene students and 22 dental assisting students. All of last year's dental hygiene graduates successfully completed the American Dental Hygiene Board Exam and graduates from both programs have found employment. Ms. Louise Fahlman King, a 1992 dental hygiene graduate, received provincial recognition when she was awarded the Governor General College Medal of Academic Excellence for outstanding achievement.

Dental assisting and dental hygiene students

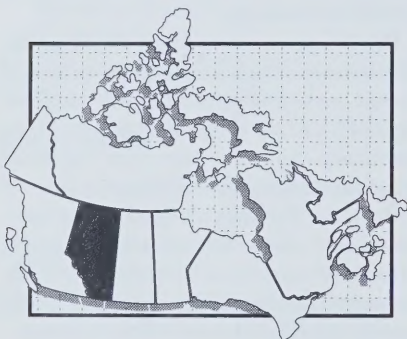


College of New Caledonia
Dental Hygiene Class 1992-1994

Top Row (l-r): Leah Messenger, Elizabeth Hatch, Lillian Roste, Deanna Martin, Barbara Maillot, Cheryl Desautels
Middle Row (l-r): Geri Wayslow, Rose Rutledge, Phyllis Fraser, Donna Chapman, Kari Legebokoff, Sharon Davalovsky
Bottom row (l-r): Sue Trevisan, Michelle Lamarche, Melanie Donaldson, Nicole Wiebe, M.J. Dunn, Jody Gerhardi, Tracy Fehr

continue to learn together in both the didactic and clinical areas at the College of New Caledonia. As of the fall of 1992, the dental reception program officially became part of the Division of Dental Studies and graduated 30 students this year. The College once again provided facilities to OLA (Open Learning Agency) for their dental assisting practicum. The dental hygiene accreditation site visit went extremely well and we were awarded full status for seven years.

Our division chair, Ms. Fran Richardson Cotton, was elected President of CDHA at the June annual meeting. We wish her good luck. Patricia Covington continues to serve on the CDHA Board of Directors. The majority of faculty members are actively involved in their respective professional organizations. CNC will celebrate its silver anniversary next year and a number of special activities are being planned to commemorate this event.



University of Alberta School of Dental Hygiene Edmonton, Alberta

The 1992-93 academic year marked the second phase of the Dental Hygiene Program expansion. The quota for the first-year class was expanded to 65 students, with 48 students continuing in the second-year class. We were fortunate to welcome several new staff members this year. Professor Eunice Edgington (from Toronto), joined the full-time faculty. Her primary teaching areas included Hospital Dentistry, Specialities and Communication. New part-time faculty are Patricia Gainer, Heather MacDonald, Wendy MacKinnon and Marina Proserpi-Porta.

Presently the Dental Hygiene Program consists of 3 full-time staff and 27 part-time staff, including 4 consulting dentists. Recently, several part-time faculty members were recognized for their long-standing service and teaching contributions to our faculty. Those recognized for long-service were Anita Eastwood (15 years), Paulette Schulte (10 years), and Dr. J. Theodore (30 years). Three part-time faculty members were recognized for their exemplary teaching contributions

and promoted to Clinical Associate Professor are Anita Eastwood, Janice Ritchie and Margaret Wilson. Additionally, Dr. J. Theodore was recognized for his outstanding teaching and overall contribution to the dental hygiene faculty and promoted to Clinical Professor. It is our pleasure as full-time faculty to work with an outstanding group of part-time academics.



Saskatchewan Institute of Applied Science and Technology Wascana Institute Dental Hygiene Programs Regina, Saskatchewan

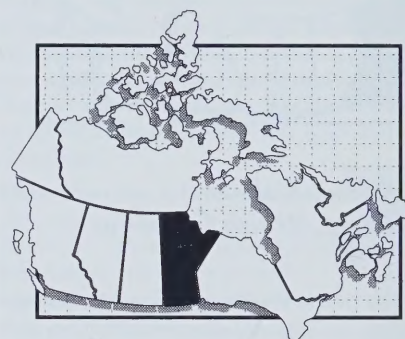
Wascana Institute enrolled 30 students into its Dental Hygiene Program in the fall of 1992. Of those students, ten were dental therapists who directly accessed the Dental Hygiene II Program after completing the remedial exams and 20 were Dental Assistants who had just completed the Dental Hygiene I Program the previous May. Graduate celebrations were held at the end of April, and most students completed their courses by the end of May.

Faculty and students had a very busy and productive year. Several additions were made to the course over the past year to increase its focus on dental hygiene as a client-centred process of care.

The community oral health course was enhanced to include information on health reform in Saskatchewan with the new focus on wellness. Pioneer Village and the Saskatchewan Abilities Council participated in two new initiatives which implemented Community and Oral Health Promotion projects. Students and a faculty member provided oral screening exams to the participating residents of Pioneer Village Nursing Home and oral health education to the residents and staff. The Saskatchewan Abilities Council is an organization which works with the mentally handicapped. Dental hygiene students worked with the Abilities Council clients on a one-to-one basis and in group sessions to provide oral health information and oral hygiene instruction. We anticipate these two projects to be ongoing in the future.

Also in the area of oral health promotion, our students presented table clinics on oral health and oral hygiene projects to various other client groups in the Regina area.

The Dental Hygiene I Program enrolled 22 students in January 1993. Upon completion of the Dental Hygiene I Program, these former dental assistants will continue on to the Dental Hygiene II Program with a number of dental therapists in the fall of 1993.



University of Manitoba School of Dental Hygiene Winnipeg, Manitoba

Marnie Forgay returns to the School August 1, 1993, after completing a one-year sabbatical in Biera, Mozambique where she worked in a joint project of the University of Saskatchewan and the Government of Mozambique. Regrettably we will lose two faculty members in May 1993: Annetta Streater who served in the position of first-year clinic co-ordinator since 1991, will return permanently to her home in North Carolina and Laura MacDonald, who has responsibilities for teaching in community health and communication, and supervising student externs along with special projects, will leave temporarily for one year to move to North Carolina with her family.

During the 1992-93 academic year a transition was completed whereby curriculum changes took place in our program. Changes to our admission requirements including the completion of five prerequisite university courses and an interview process have been in place now for two years. The School has submitted an application to the University's Program Development Fund for financial support to implement its approved degree completion baccalaureate program in dental hygiene. In February of this year, the School underwent an accreditation site visit.

In November 1993, the School will conduct a faculty development workshop which will be facilitated by Professor Denise Bowen, Head of the Dental Hygiene Program at Idaho State University. The workshop will focus on applying the Dental Hygiene Human Needs Conceptual Model to the clinical teaching program.



Confederation College Thunder Bay, Ontario

Confederation College experienced many changes this academic year. Gail Sargent is the new Co-ordinator of the Dental Assistant and Dental Hygiene Programs. Salme Lavigne retired from Confederation College and accepted the position of Director of the Dental Hygiene Degree Program at the University of Wichita, Kansas.

Gail Sargent and Salme Lavigne have been liaising over possible future international exchange programs.

We greet a new faculty member, Maureen Harrington, from Peterborough, Ontario. She recently completed a Bachelor of Science in Dental Hygiene at the University of Kansas City, Missouri.

Further changes have included restructuring of the program to two eighteen-week semesters, planning alternate delivery methods and, in general, attempting to maintain quality programs.

Sue Raynak continues to be actively involved on CDHA and ODHA Boards of Directors. Gail Sargent is the incoming ODHA Director for Thunder Bay.

All faculty attended the CDHA-ODHA Convention in Toronto during May, and are enthusiastically anticipating the Research Conference to be held in Niagara Falls in October, 1993.

St. Clair College of Applied Arts and Technology Windsor, Ontario

Our class of 30 students had a busy year. The academic challenge for this group of students evolved around the implementation of more independent learning situations than in previous classes. Faculty diligently and professionally prepared appropriate sections from their courses into learning packages. Funds were available to purchase learning resources. Our students accepted the challenge and discovered that their problem-solving abilities improved as a consequence. These skills were used when completing their patient dental

hygiene treatment plans. Excellently and professionally prepared, these plans reflected the goals and needs of the patients and established individual appropriate patient care.

The clinical component at St. Clair continues to be competency-based. The students often work with the dental assistant students that encourages a collaborative practice situation in our busy clinic. Patient recruitment activities were extremely active this year which resulted in a large patient resource.

Renovations were completed in June to incorporate a large sterilization preparation room. The program's locker room facilities were also enlarged in the spring for our 1993-4 students to enjoy. Special thanks to Helen DiMenna, a St. Clair College clinical instructor and president of the Windsor Essex County Dental Hygiene Component Society for preparing such a wonderful and educational program this past year. We appreciate her hard work.

Georgian College Orillia, Ontario

Fourteen full-time and two part-time students enrolled in the Dental Hygiene program at Georgian College during the 1992-93 academic year. The students were busy with theory and clinic but found time to make presentations to two community groups and the Simcoe County Dental Hygienist's Society. They also benefited from a series of workshops and clinical surgical sessions conducted by a local periodontist.

The highlights of the past year include receiving full accreditation status for seven years and signing of an articulation agreement with the Forsyth School for Dental Hygienists in Boston. This enables accepted graduates from the Georgian College program to obtain a Bachelor of Science in Dental Hygiene and the Certificate in Advanced Dental Hygiene Science from the Forsyth School of Dental Hygienists and Northeastern University, over a period of 2 to 2 1/2 years of full-time study.

George Brown College Toronto, Ontario

During the 1992-93 academic year at George Brown College, 48 students were enrolled in the dental hygiene program.

The main theme for this year focused on asepsis and infection control and the renowned guest lecturer, Dr. John Molinari, addressed the faculty, students and invited guests from other institutions.

The incorporation of a more problem-based clinical curriculum was of paramount importance and has formed the basis for professional development for the faculty. Once again, rep-

resentatives from other institutions took part in these activities. An integrated approach for dental hygiene and dental assisting students continues to be emphasized, and this year preventive dentistry provided this opportunity.

Under the direction of Dean Lynne Mulder, Chair Doug Stulla, Dental Hygiene Co-ordinator Evie Jesin, and Accreditation Co-ordinator Helga Cuddy, the Dental Hygiene Program prepared for an accreditation site visit in March.

George Brown College will continue to hold a two-week dental hygiene refresher course in July 1993, and a one-week clinical course to assist candidates prior to taking the licensing examination as part of the College's continuing education.

Durham College of Applied Arts & Technology Oshawa, Ontario

As we approach the end of another year, we reflect on how our committed staff have shaped the professional skills of yet another 52 dental assistant students and 23 dental hygiene students.

Dental assistant students have valued their work experience in local dental offices, at the Faculty of Dentistry, University of Toronto, and visits to dental clinics at St. Michael's Hospital and Mount Sinai Hospital.

In our Dental Hygiene Program, development of community experience programs has been ongoing, allowing our students insights into all aspects of dental health education.

La Cité Collégiale Ottawa, Ontario

Depuis la création du premier collège francophone en Ontario en 1990, les programmes dentaires de La Cité collégiale ont été très occupés à se faire une place au sein des associations et des corps gouvernementaux. Dès la première année, c'est-à-dire en 1990, les programmes dentaires ont eu à se faire évaluer par l'Association dentaire canadienne afin de recevoir l'agrément. La Cité collégiale est maintenant officiellement reconnue par l'Association dentaire canadienne depuis novembre 1991. Les deux coordonnatrices travaillent constamment dans le but d'adapter, de mettre à jour et d'améliorer les cours offerts aux étudiant-e-s qui fréquentent ce collège.

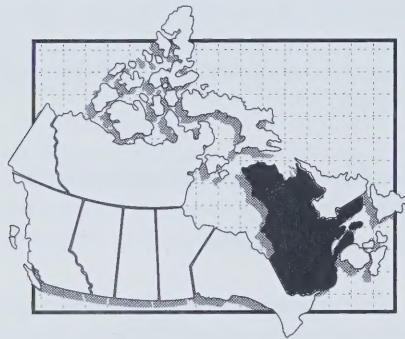
Nous avons 14 étudiantes inscrites au programme d'hygiène dentaire et 24 d'inscrites en Soins dentaires. Les étudiant-e-s doivent faire la navette à la clinique dentaire du collège Algonquin pour les laboratoires et les sessions cliniques. Tous les cours théoriques sont offerts dans les locaux de La Cité collégiale. En

septembre 1995, La Cité collégiale aura son site permanent et sa nouvelle clinique dentaire.

Sylvie Martel, coordonnatrice du plan d'études des programmes dentaires, a été nommée au conseil transitoire du futur Ordre des hygiénistes dentaires de l'Ontario.

Linda Bélanger, coordonnatrice du champ clinique et communautaire des programmes dentaires, a été nommée présidente du Regroupement des hygiénistes dentaires francophones en Ontario.

Félicitations aux deux!



John Abbott College Ste Anne de Bellevue, Quebec

For the past few years, the John Abbott College Dental Hygiene Program has experienced an increase in its number of applicants. The 92-93 academic year was no exception; 100 applications were received for a maximum capacity of 32. Nonetheless, 33 new students enrolled in the fall and, in May, 23 graduated.

For the past ten years, the Dental Department of the Jewish General Hospital in conjunction with the Dental Hygiene Department of John Abbott College has hosted a one-year residency program for two dental hygienists. The two dental hygiene residents work in co-operation with the dental residents. Aside from attending seminars and participating in studies, the residents are called upon to treat HIV positive clients, elderly people, and many other somewhat complex cases. And this year, one of our graduates was selected as one of the residents.

Again last November, third-year dental hygiene students together with McGill dental students participated in a one-day community activity teaching oral hygiene in several schools in the greater Montreal area.

In recent years, once every month, our dental hygiene clinic at the Montreal Children's Hospital is used for a Cleft Palate Clinic. The patients, children for the most part, are seen by dentists and specialists. Third-year students participate on a rotational basis. They review oral hygiene with the patients and whenever necessary they do prophylaxes. Students generally enjoy this and find it to be a very beneficial experience.

By mid-April there is still no news about the pending clinic move to the college campus. While anticipating the long awaited news, faculty has kept busy with school work as well as other professional activities. Three faculty members were involved in accreditation site visits. Gisele Johnson was elected vice-president of the CPHDQ, our licensing body. Charla Lautar is presently completing her PhD at the University of Calgary. Her colleagues would like to take this opportunity to wish her the best upon this final phase of her doctorate.



Dalhousie University School of Dental Hygiene Halifax, Nova Scotia

The School of Dental Hygiene at Dalhousie University has a current enrollment of 80 students: 40 in each of the two years. Our students range in age from 19-45 years. There are currently three male students in the program. Students come from many diverse social, economic and cultural backgrounds. Our student profile has changed remarkably and now includes many mature students, some embarking on a second, or third, career. Dalhousie University has an affirmative action program and the School of Dental Hygiene has been a

leader in the Faculty of Dentistry in the recruitment and retention of indigenous Black and native students.

The faculty consists of the Director, Joanne Clovis, and four full-time faculty. We also have 23 part-time faculty members including several dentists.

The clinical program at Dalhousie is competency based. The students are paired with a fourth-year dental student in a General Dentistry setting to create a greater similarity to a collaborative clinical practice setting.

All students receive pediatric experience in a school program where they are paired with senior dental students in a clinical setting. At Dalhousie, students have an opportunity to work in an Oral Pathology clinic and a Periodontic post-graduate program.

Ten students annually participate in an extramural practice experience in Newfoundland at the Grenfell Mission in St. Anthony. Pairs of senior students spend a two-week rotation treating patients in the dental clinic at the hospital and learn a little about life "on the rock".

Students are also involved in a satellite clinic setting at Mount Saint Vincent Mother House in Halifax, where they provide clinical services and spend a great deal of time educating the residents and care givers.

The senior students have just completed their Table Clinic presentations. This year for the first time, a senior dental hygiene student, Bhupinder Singh, presented a paper entitled "Long-Term Sub-Cutaneous Tissue Reaction to Experimental Denture Soft Polymers" at the IADR meeting held in Chicago during March.

The academic year wound down for the senior students with convocation at the end of May while those enrolled in the first-year program continued until the end of May.



CDHA extends its congratulations to all the new dental hygiene graduates, and encouragement to those who are now entering their final year. Those pictured here will graduate from the program at the College of New Caledonia in 1994. (Thanks to Barbara Maillot for submitting the photo!)

Calendar

September 1993

		SPONSOR	LOCATION	FOR INFO CALL
10	Dentotherapeutics — Dr. Sebastian Ciancio	University of Alberta	Edmonton, AB	(403) 492-5023
18	Infection Control — C. MacLean; H. Bowers	Dalhousie University	Halifax, NS	(902) 494-1674
18	Computers in Your Practice — C. Greer	Dalhousie University	Halifax, NS	(902) 494-1674
23	Evening Program in Periodontics	University of Toronto	Toronto, ON	(416) 979-4503
25	Improve Your Instrument Sharpening Skills — J. Pimlott, A. Eastwood, P. Schulte	University of Alberta	Calgary, AB	(403) 492-5023

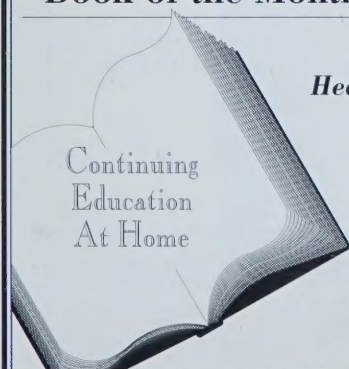
October 1993

2	New Perspectives in Treating Older Patients — Dr. P. Lloyd	Dalhousie University	Halifax, NS	(902) 494-1674
15-17	CDHA's Professional Conference — An Exploration into the Future: A North American Research Conference	Canadian Dental Hygienists Association	Niagara Falls, ON	(613) 728-8730
16	Current Developments in Restorative Materials and Techniques — Dr. K. Leinfelder	University of Alberta	Calgary, AB	(403) 492-5023
23	Early Orthodontic Treatment: The Good, The Bad, & The Ugly — Dr. David Kennedy	Dalhousie University	Halifax, NS	(902) 494-1674
23-24	Preventive Dentistry Forum	University of Toronto	Toronto, ON	(416) 979-4503
30	Basic Rescuer CPR and Airway Management — Canadian First Aid School	University of Alberta	Edmonton, AB	(403) 492-5023

November 1993

6	X-Ray X-Cellence — Dr. B. Pass, Dr. T. Blackmore	Dalhousie University	Halifax, NS	(902) 494-1674
6	Current Concepts in Non-Surgical Periodontal Therapy — Prof. Denise Bowen	University of Manitoba	Winnipeg, MB	(204) 789-3331
12-13	Strengthening Dental Hygiene in Today's Practice — Dr. J. McDonald, Ms. K. Helborn, Ms. P. James	University of Alberta	Calgary, AB	(403) 492-5023
18-21	Canadian Bioethics Society's 5th Annual Conference	Canadian Bioethics Society	Montreal, PQ	(514) 343-2142
26-27	Clinical Photography: A Hands-On Approach — Dr. P. Major, Mr. D. Marston	University of Alberta	Edmonton, AB	(403) 492-5023

CDHA's Book of the Month Suggestion



July:
Healing and the Mind
by Bill Moyers.
(Harper/Collins).
ISBN0385468709

August:
Shifting Gears
by Nuala Beck.
(Harper/Collins).
ISBN0002157853

“Is it ethical to deny clients with home care requirements direct access to the services of a dental hygienist?”

**FIND OUT AT CDHA'S 5TH PROFESSIONAL CONFERENCE
SASKATOON, SASKATCHEWAN, JUNE 17-19, 1994.**



Dental Jurisprudence

1. What is the primary purpose of a Professional Practice Act?
 - a) to protect the public
 - b) to govern the practitioner
 - c) to regulate the Profession
 - d) to stipulate legal functions
2. What are the conditions for a professional contractual relationship? It exists when:
 - a) stated orally
 - b) agreed in writing
 - c) implied by actions
 - d) expressed by any of the above
3. With what body does a Professional Practice Act, such as the Dentistry Act/ Dental Hygienists Act/Health Professions Act, regulate the health professional's relationship?
 - a) the Provincial Courts
 - b) the Provincial Legislature
 - c) the Human Rights Commission
 - d) the Professional Association
4. What does the concept of maintaining the "standard of Care" infer about the services rendered a patient? It implies that the treatment was:
 - a) perfectly performed
 - b) precisely performed
 - c) reasonably performed
 - d) realistically performed
5. Tort law usually applies to what legal area?
 - a) property law
 - b) civil offenses
 - c) practice agreements
 - d) employment agreements
6. What element(s) must a patient prove in a lawsuit for Malpractice?
 - a) an injury
 - b) improper treatment
 - c) lack of skill and care
 - d) improper treatment and an injury
7. What is the most critical evidence in a malpractice suit?
 - a) the records
 - b) the clinical findings
 - c) the patient's statement
 - d) the professional's statement
8. Regarding the actions of the professional, what is the most important question posed by a malpractice suit?
 - a) that he/she was experienced
 - b) that he/she exercised due care
 - c) that he/she had advanced training
 - d) that he/she was a reputable practitioner
9. Which of the following actions could result in contributory negligence?
 - a) substandard dental care
 - b) failure of the patient to pay the agreed fee
 - c) failure of the patient to follow instructions
 - d) failure of the professional to give adequate instructions
10. What action should a hygienist take if threatened with a malpractice suit?
 - a) write a letter of apology to the patient
 - b) take no action until officially notified
 - c) notify his/her liability insurance company
 - d) inform the patient of his/her insurance coverage
11. Which of the following is not required for an informed consent?
 - a) financial implications
 - b) description of "standard of care"
 - c) initiation of the proper procedures
 - d) explanation of expected treatment results
12. Which of the following terms is defined as intentional defamation of character?
 - a) fraud
 - b) libel
 - c) slander
 - d) technical assault

Answers:

- | | | | |
|-------|--------|--------|--------|
| 1. a) | 2. d) | 3. b) | 4. c) |
| 5. b) | 6. d) | 7. a) | 8. b) |
| 9. c) | 10. c) | 11. c) | 12. b) |

This self-assessment test was prepared by Brenda Leggett, RDH, Instructor and Curriculum Coordinator with Algonquin College's Dental Hygiene Program, Ottawa, Ontario.



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1993 North American Research Conference

October 15-17, 1993 Niagara Falls, Canada

Preliminary Summary of Abstracts to be Delivered at the Conference

PRESENTING AUTHOR	CITY, STATE	AFFILIATION	TITLE OF PRESENTATION	TYPE OF PRESENTATION
Bapoo-Mohamed, Karima	Edmonton, AB		Dental Implants — A Clinical Assessment of Peri-implant Tissue	Poster Session
Beatty, Chris French	Denton, TX	Texas Woman's University, Department of Dental Hygiene	TWU CARES: An Innovative Community-Based Dental Program	Free Paper
Beaver, Shirley M.	Carbondale, IL	Southern Illinois University, College of Technical Careers	Dental Hygiene Students' Perceptions Regarding Relevancy of Selected Items in the Curriculum and the Relationship to GPA, ACT, Dental Assisting Experience and Other Personal Factors: A Pilot Study	Poster Session
Bly, JoNell, M.	Vermillion, SD	University of South Dakota	Prison Dentistry in South Dakota	Poster Session
Borowko, Maxine	Maple Ridge, BC	Pacific Health Care Society	Long Term Care Dental Hygiene Project	Free Paper
Brunick, Ann	Vermillion, SD	University of South Dakota	Dental Care of Native Americans of the Plains States	Poster Session
Cobban, Sandra	St. Albert, AB	Sturgeon Health Unit	Toothpaste Ingestion by Pre-School Children	Poster Session
Compton, S.M.	Edmonton, AB	University of Alberta	Desensitizing Agents and Tubular Occlusion	Poster Session
Craig, Bonnie J.	Vancouver, BC	University of British Columbia Department of Clinical Dental Sciences	Dental Hygiene Degree Program	Table Clinic
Craig, Bonnie J.	Vancouver, BC	University of British Columbia Department of Clinical Dental Sciences	University of British Columbia Dental Hygiene Degree Completion Program	Free Paper
Dempster, Laura	Toronto, ON	University of Toronto Faculty of Dentistry	Assessing Clinical Competence Using Oral Examinations	Free Paper
Detmold, Liana	Red Deer, AB	Red Deer Regional Health Unit	Grade Seven Tobacco Products Survey	Poster Session
Dunphy, Julie	Norfolk, VA	Old Dominion University College of Health Sciences	The Effects of State Dental Practice Acts on the Scope of Dental Hygiene Services Provided by Public Health Dental Hygienists	Free Paper
Forrest, Jane	Philadelphia, PA	Thomas Jefferson University Department of Dental Hygiene	Development of The Dental Hygiene Research Curriculum Learning Outcomes	Free Paper
Gleber, Jaclyn	Philadelphia, PA	Thomas Jefferson University Department of Dental Hygiene	Interpersonal Communication Skills for Dental Hygiene Students: An Innovative Training Program	Free Paper
Gurenlian, JoAnn	Philadelphia, PA	Thomas Jefferson University Department of Dental Hygiene	The Use of Lasers in Dental Hygiene	Free Paper
Hamman, Kristin A.	Pocatello, ID	Idaho State University Department of Dental Hygiene	Factors Influencing Dental Hygiene Retention in the Private Practice Setting	Free Paper
Hardy, Deborah L.	Dallas, TX	Baylor College of Dentistry Caruth School of Dental Hygiene	Cultural Diversity: A Dental Hygiene Prospective	Free Paper
Hayre, Mandeep	Vancouver, BC	University of British Columbia Department of Clinical Dental Sciences	Tools for Organizing Dental Hygiene	Free Paper
Hodges, Kathleen	Pocatello, ID	Idaho State University Department of Dental Hygiene	Patient Attitudes About Rubber Cup Polishing and Airpolishing	Poster Session
Isaac, Susan	Victoria, BC	Camosun College Dental Hygiene Program	Student Directed Learning Using Written Tests	Free Paper
Johnson, Patricia	Willowdale, ON	Seneca College	International Profile of Dental Hygiene: 18 Country Comparative Study (1988 and 1992)	Free Paper
Keselyak, Nancy & Maschak, Linda	Port Coquitlam, BC	University of British Columbia	A Critical Analysis of Continuing Education for Dental Hygienists in British Columbia	Free Paper

CDHA gratefully acknowledges the generous support of the CFDE & Health and Welfare Canada for this conference.

PRESENTING AUTHOR	CITY, STATE	AFFILIATION	TITLE OF PRESENTATION	TYPE OF PRESENTATION
Keselyak, Nancy & Maschak, Linda	Port Coquitlam, BC	University of British Columbia	Quality Assessment in Continuing Education: An Instrument Sharpening Workshop Example	Poster Session
Kwapis-Jaeger, Judy	Detroit, MI	University of Detroit Mercy School of Dentistry	Law and Ethics: A Realistic Approach	Free Paper
Lautar, Charla J.	Calgary, AB	University of Calgary	The Professionalization of Dental Hygiene in Alberta: A Focus Group	Free Paper
Loiacono, Carla	Dallas, TX	Baylor College of Dentistry Caruth School of Dental Hygiene	Dental Hygiene Students Attitudes Towards Disabled Populations	Poster Session
Long, Barbara	Saskatoon, SK	University of Saskatchewan College of Dentistry	Further Evaluation of a New Periodontal Curet	Poster Session
MacDonald, Laura	Winnipeg, MB		Student Teachers' Oral Health Knowledge	Free Paper
Maloney Solt, Karen	Chicago, IL	Northwestern University	Utilization of Dental Hygienists as Instructors in Periodontics	Free Paper
Martin, Brenda Sue	Philadelphia, PA	Thomas Jefferson University Department of Dental Hygiene	Assessment Procedures Used to Determine Need for Dental Radiographs	Free Paper
McCann, Ann		Baylor College of Dentistry Caruth School of Dental Hygiene	An Information Center for the Assessment of Outcomes in Dental Hygiene	Free Paper
Mueller, Jodie A.	Norfolk, VA	Old Dominion University Department of Dental Hygiene	Self-Regulation: Its Effects on Disciplinary Action and Licensure Requirements of Dental Hygienists	Free Paper
Nelson, Debralee M.	Vermillion, SD	University of South Dakota	Patient and Operator Acceptance of Electronic Dental Anesthesia	Poster Session
Nelson, Robert	Vermillion, SD	University of South Dakota	Use of Electronic Dental Anesthesia with Extraoral Electrodes in Dental Hygiene	Table Clinic
Newell, Kathleen	Minneapolis, MN	University of Minnesota Division of Dental Hygiene	Upper Extremity Positions During Dental Hygiene Procedures	Table Clinic
Nielsen-Thompson, Nancy	Iowa City, IA	University of Iowa Dental Hygiene Program	Methodological Problems in Sampling Using Lists of Licensed Dental Hygienists	Free Paper
Osborn, Joy B.	Minneapolis, MN	University of Minnesota Division of Dental Hygiene	A Comparison of Hand- and Machine-Sharpended Curets	Table Clinic
Pimlott, J. F. L.	Edmonton, AB	University of Alberta	Solar Powered Toothbrush: Effect on Salivary pH	Poster Session
Pimlott, J.F.L.	Edmonton, AB	University of Alberta	Scaling Gel: The Effect on Cementum	Poster Session
Pimlott, J.F.L.	Edmonton, AB	University of Alberta	Reflection of Feeling Content & Empathy Important Skills in Professional Education	Free Paper
Reveal, Marge	Victoria, BC	Camosun College	The Toothbrushing Ability Test in Elderly Patients	Free Paper
Riccelli, Angelina	Pittsburgh, PA	University of Pittsburgh	Early Onset Periodontitis: Relationship Between Neutrophil Function and Seropositivity to Aa	Free Paper
Richardson Cotton, Fran	Prince George, BC	College of New Caledonia	Integration: Not a Novel Approach	Poster Session
Robertson, Pat	Vancouver, BC	University of British Columbia Department of Clinical Dental Science	Ethical Decision-Making In 1990s Dental Hygiene Practice	Table Clinic
Robertson, Pat	Vancouver, BC	University of British Columbia Department of Clinical Dental Science	Moving Ahead with a Paradigm for Dental Hygiene	Free Paper
Rowe, Linda	Rock Island, IL	University of Iowa	Relationship Between Dental Hygiene Assessment Practices and Patients' Oral Health	Poster Session
Somlyai, Judith	Vancouver, BC	University of British Columbia Department of Clinical Dental Science	Applying Individual Ideas to Theory Development for Dental Hygiene	Free Paper
Stokes Streater, Annetta	Winnipeg, MB	University of Manitoba	A Dental Hygiene Model for Addressing Cultural Diversity Among Students	Free Paper
Strevens, Linda	Toronto, ON	Royal College of Dental Surgeons of Ontario	Self-Regulation — Is It A Privilege?	Table Clinic
Thordarson, Helga	Vancouver, BC	University of British Columbia Faculty of Dentistry	Oral Complications of Out-Patient Chemotherapy	Free Paper
Vendemia, Maureen & Harig, Laurie	Youngstown, OH	Youngstown State University	Electronic Testing of Latex Glove Integrity	Table Clinic
Willette, Susan J.	Johnson City, TN	East Tennessee State University Department of Dental Hygiene	The Relationship of Personality Type to Leader Style and Perceived Effectiveness Among Dental Hygiene School Administrators	Free Paper



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☐ Theory Development ☐ Testing & Validating Dental Hygiene Theory ☐ Survey Research

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Registration for Friday Workshop Only

Date: Friday, October 15, 1993 **Place:** Sheraton Fallsview Hotel, Niagara Falls, Ontario
Time: 9:00 to 4:00 **Registration Fee:** \$35.00 (includes lunch)

Information from Registrants:

Name: _____

Address: _____

Current Dental Hygiene Involvement:

Identify the area in which you spend the major part of your time:

☐ Community Health ☐ Licensing Organizations ☐ Clinical Practice

☐ Education ☐ Other _____

(if yes, name of program)

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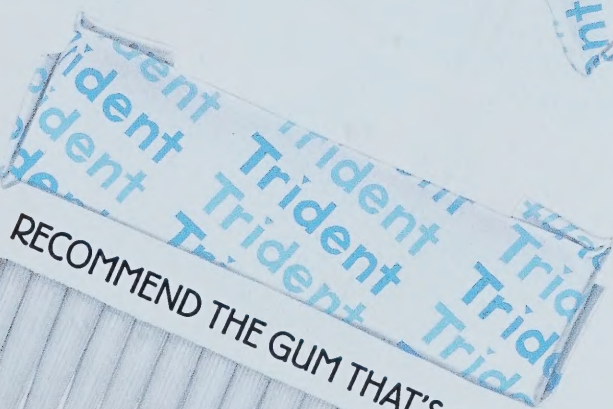
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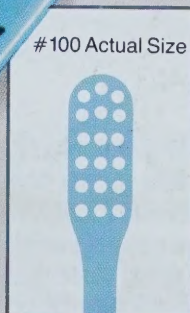
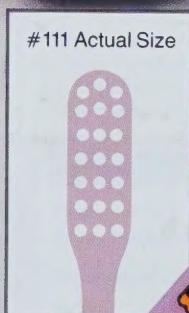
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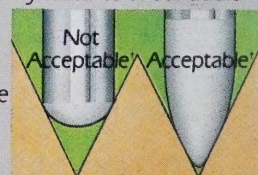
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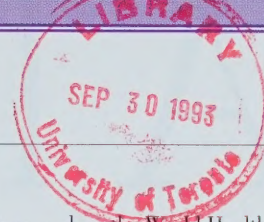
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Me... at the Research Conference? But, I'm Not in Research

Of course you're in research! Each time you invite a client to sit in your chair and open his or her mouth, you begin to seek out anomalies that are outside the range of normal limits, you locate and document plaque and inflammation, perhaps even by use of an index, you relate this information to the ensuing loss of attachment and you measure this defect with a standardized probe. Your mind begins to see patterns which lead you to conclusions about the treatment you will provide for this client. You are, at that moment an investigator, and you are using information which someone, at some time, has documented as relevant to either a state of disease or health. You're in research each and every day, in the operatory, in the community or in the classroom.

What you may need is a better understanding of just how you have been using research techniques in your work and how you may better understand them to employ them even further and more effectively in the future. This upcoming research conference is designed to provide that understanding; how does research really apply to the clinician, the community health care worker, the educator? It will help you to see how a research question is conceived, developed, implemented, analyzed, validated, reported and finally transmitted.

The CDHA North American Research Conference "An Exploration into the Future", in Niagara Falls this October, really is just for you!

Dental hygiene is on the very brink of establishing its own research agenda. We have already begun to fund our own people and in doing so, have examined and evaluated the questions they choose to investigate.

If we consider the evolution of dental research to date we must begin with the first major revolution in modern times — the discovery of the caries-preventive actions of fluoride. With this discovery came the recognition of the importance of epidemiological research, chemical analyses, and animal research. From there studies on the biochemistry and biophysics of the fluoride mineral, as it relates to the tooth structure and development, were fostered. Strides were also made in the understanding of the caries disease process and the analyses of the fluoride mechanism in action. All these directions came from one scientific conclusion!



MARILYN GOULDING, RDH, BSc

The second major revolution came when it was proven that dental caries and the periodontal diseases were infections associated with bacteria in dental plaque. From there doors were opened to examine the relationship of microbiology and immunology, the protective qualities of saliva and conversely the dangers of xerostomia, and naturally, in sequence, the associations of diet to the disease health continuum.

Finally there evolved a focus on collagen, that basic structure of the dentin and cementum, skin, connective tissue and bone. This added to the knowledge base critical information on structure and function, the inflammatory process, wound healing and cancer metastases.

This pattern of discovery leading to discovery, with doors opened along the way, has been repeated in the areas of pain and behavioral science, biomaterials and diagnostics. It has been the basis of the work done in the area of the oral manifestations of AIDS, certainly one of the more demanding and urgent areas of study in the past decade.

Has it been by chance that the studies have progressed so conveniently in this manner? Dentistry has developed a very well planned and directed template for the progression of research through its body known, in North America, as the National Institute of Health. This organization works collaboratively with

others such as the World Health Organization, the Pan American Health Organization and the Fédération Dentaire Internationale. There has also been a great contribution by the disease-support groups who catalogue current information and work with researchers interested in their particular areas. Many groups have established regional diagnosis and treatment centers that serve as sites for collaborative studies. They develop patient registries that could provide a source of study panel volunteers for samples in clinical trials. Such registries also provide a source of familial connections which are of interest to those studying genetics or epidemiology. This type of collaboration is also able to be initiated with "special-needs" groups and minorities.

As you can see dental hygiene researchers can and do fit well into all of these research need areas. But not all of these areas fit well with the interests of dental hygiene; they are primarily developed by dental researchers. As we ease over this summit, on the brink of dental hygiene research we must investigate the need for a body of our own to establish research priorities. We need to identify the areas of particular interest to the profession of dental hygiene and establish an agenda. These priorities should never be so stringent as to stifle new discovery but should be based on criteria that will have a future impact on this nation's health and build on the existing science and technology base. Research requires a continuum to develop and an organized body to monitor its growth so that clinical "payoffs" provide the profession with the impetus to go on. What happens in the laboratory needs to make its way into the operatory.

With conferences such as the one to be held in Niagara Falls this October we have begun to build the road. All of us need to be present for this interaction; those with the test tubes, those with the text books and those with the toothbrushes. Help us to initiate this dissemination of information from the laboratory to implementation in the operatory. Only then is all the work worthwhile.

If this profession of dental hygiene has been good to you, then help it grow; help it evolve. Come to Niagara Falls and see the tremendous force of one of Nature's wonders and wonder at the tremendous force of your profession in action. See you there!

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COVER

Marilyn Goulding graduated from the University of Alberta, Dental Hygiene program in 1977, obtained a Bachelor of Science in Clinical Research and Dental Hygiene Education from Empire State College in 1988, and is currently a candidate in the Masters of Oral Science Program at the University of Buffalo. She has worked in clinical practice, in clinical research and in education over the past sixteen years. Presently she is a faculty member at Niagara College and is serving her fourth year as the scientific editor of *Probe*. Marilyn will be presenting two papers at the upcoming research conference; one on Microdiagnostics and one in conjunction with the ADHA Journal on manuscript preparation. In her spare time Marilyn and her family enjoy the many beautiful sights in the Niagara Peninsula. She invites you all to come and join her and the many hygienists from the United States and Canada for an "Exploration into the Future" at the CDHA fourth annual professional conference being held October 15-17 in Niagara Falls, Ontario.

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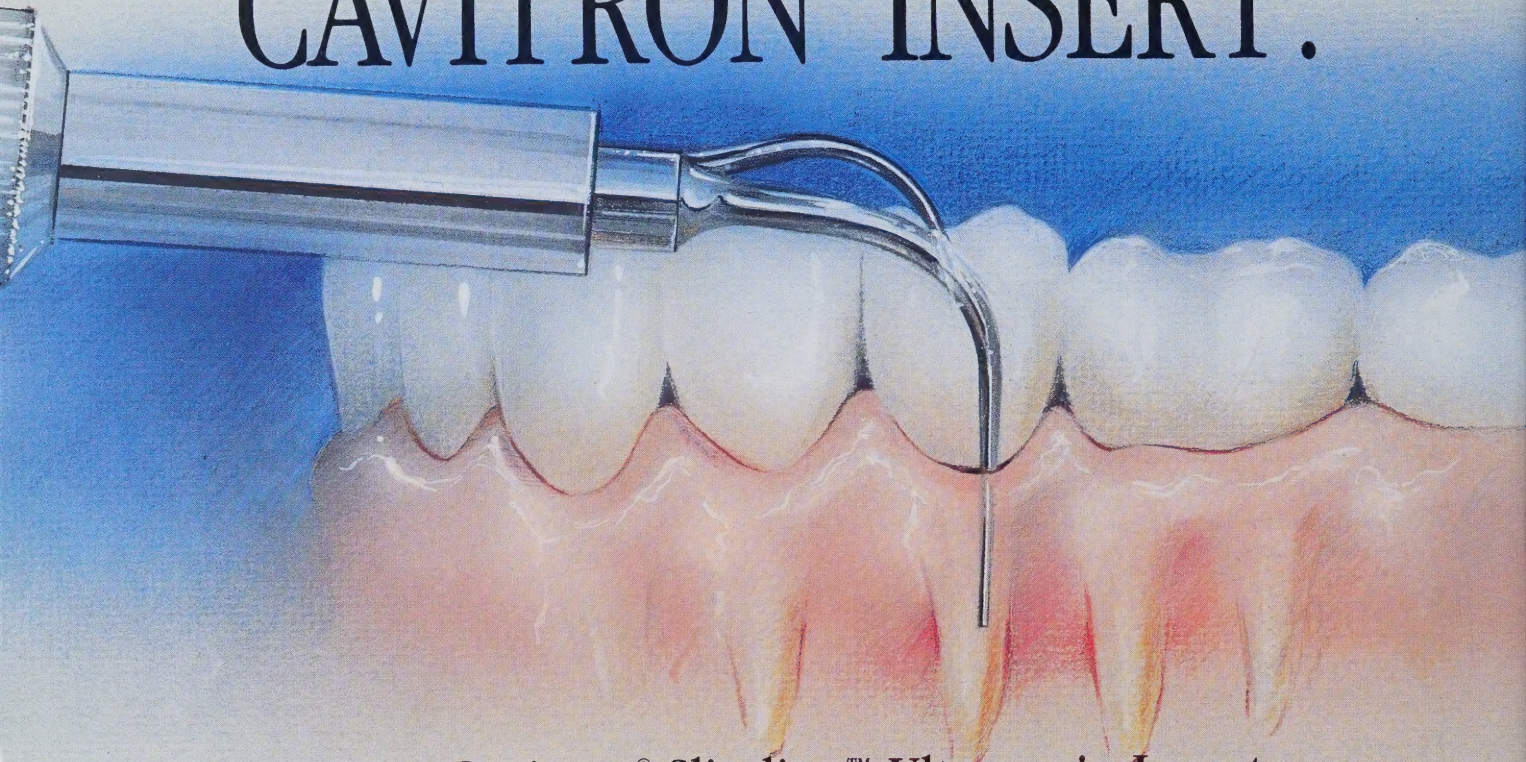
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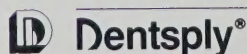
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Questions?

At this time of writing, it is summer and June has had its final day. June is always a busy time for me, part of the joy of being in the educational field and being on CDHA Executive. During June our college graduated twenty dental hygienists and twenty-two dental assistants. I wonder what their futures will bring?

June is also the month the CDHA Board of Directors meets and hosts CDHA's Annual General Meeting. Preparations for this event are often arduous and the travel time, for some, quite extensive. For each trip to Ottawa, I must add a day of travel time on either side of the meeting. Your colleagues donate generously of their time and talent during this yearly session — and they are always mindful of who they are representing — you — the member. CDHA's Member Services Council is aptly named as the members of this council are actively seeking new ways to serve you better. I wonder if we are meeting your needs?

This June, prior to the board meeting, a task force of dental hygienists met to continue updating the dental hygiene profession's Practice Standards. This group then presented the outcomes to CDHA's Professional Development Council. The members of this council are charged with the responsibility of facilitating the implementation of the results. The revised Standards for the dental hygiene profession will focus on the dental hygienists' multifaceted roles: as health promoters/educators, clinicians, researchers and administrators. We now recognize that all of us, no matter what our practice setting choice may be, utilize these four roles to some degree or another on a daily basis. Most of us tend to seek specific practice settings depending on our comfort level with each of these roles and dependent on our own unique gifts. Do you recognize yourself in each role?

June is often a time for acceptance into college programs. A time when potential students make life choices. More and more individuals are choosing to apply to dental assisting and dental hygiene programs. Economic times are tough; people are looking for career changes. Dental hygiene continues



FRAN RICHARDSON COTTON
RDH, BScD, MEd

to offer interested individuals a rewarding and challenging career path. What are we doing to ensure the tradition continues?

Three provinces have achieved self-regulation for dental hygiene, one province is very close, others are investigating the procedures necessary to lobby government. CDHA's Practice and Regulation Council has worked diligently on this issue and is now focusing on the development of policies on a number of contentious issues, including the use of fluorides, infection control and portability. Have you thought about what these issues could mean to your every day practice?

Due to the economic crunch and fewer health dollars to go around, governments are seeking increased community involvement from health care professionals. CDHA's Health Promotions Council is intimately involved in getting the message out to community groups that oral health care is of vital importance and that dental hygienists are available to share in community health care responsibilities. What are you doing in your community?

All of the above questions are meant to be rhetorical. We all need to question our own actions, our own beliefs and our own dedica-

tion to the profession. How can we ensure a bright future for dental hygiene? Perhaps the most important question is: **HOW CAN I HELP?**



Fran is currently Chair, Division of Dental Studies, College of New Caledonia, Prince George, BC. She received her Diploma in Dental Hygiene from the University of Toronto in 1971, a BScD from the University of Toronto in 1982 and a Masters in Education from the University of Regina in 1987.



National Dental Hygiene Week Activities

Dear Editor:

I am writing concerning an error which was printed in your March/April issue of *Probe* magazine (Vol 27 No 2).

In your summary of National Dental Hygiene week activities you mentioned that "Halifax, N.S. gave out bridge grab bags at a Seniors bridge game".

One of our activities was to give out "grab bags" containing fact sheets, brushes, floss etc. to motorists as they commuted between the cities of Halifax and Dartmouth. The location we chose was the Sir John A. MacDonald Bridge which connects the above-mentioned cities.

Please find enclosed a picture of our volunteers Terry Mitchell (left) and Norma Houston (right).

Thank you,

Alison MacDougall
1992 NDH Campaign Coordinator —
Nova Scotia



Behind Every Great Smile.....

Behind every one of these great smiles there really is a dental hygienist! That's because this photo is a montage of the smiles of the University of Alberta's Dental Hygiene Class of 1993. The original artwork was put together by Moneca Randel, an Edmonton artist, in no less than six hours. Randel said she cut out each mouth from other photographs, pasted them to a background and then laser-printed copies for each of the graduates.

Thanks to CDHA member, Eunice Edgington, of Edmonton, Alberta for suggesting we run the photo!

Probe Articles

Dear Editor:

There are a number of interesting articles in the Canadian Dental Hygienists Association's *Probe* Magazine. In organized dentistry's discussions with the dental hygiene community, with regard to the issues that currently face us, I think we sometimes lose sight of the fact that dental hygienists take a serious view of their professional responsibilities and value the care that they deliver to patients as much as dentists do. I don't know that we give full appreciation to the body of knowledge there is with regard to scaling and root planing, and the difficulty of the procedure if it is properly done.

In the President's message, (Vol 27 No1), the President enumerates a number of the thorny issues that face the average dental hygienist in practice. I certainly have had calls from dental hygienists over the years on virtually all of these issues where the dental hygienist is frustrated by the general practitioner's attitude towards issues that the dental hygienists sees as important. Examples include: being allowed the time to completely remove deposits and complete the periodontal initial therapy, and some dentists' disinterest in checking with the patient's physician with regard to reported heart murmurs and other medical complications.

An article in *Probe* (Vol 26 No 4) which I found valuable was a literature review of scaling and root planing, which included an extensive bibliography. This area of dental treatment is not merely removing the obvious deposits although my periodontist acquaintances report to me that unfortunately the level of periodontal care delivered by general practitioners has not risen commensurably with the rise in other areas of care such as restorative dentistry. I believe that our B.C. Adult Health Survey

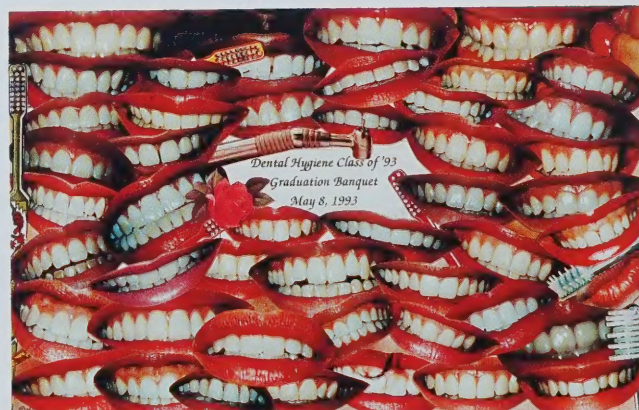
bears out this information as, in a time when dentists are reporting they are not completely busy, we still have periodontal disease identified as a major treatment area that needs more attention.

Another *Probe* article I found interesting was a thoughtful dissertation on supply and demand for dental hygienists and some of the facets that might be looked at in any dental health human resources model. This is an area that all of dentistry and government should not continue to ignore.

G.R. Thordarson, DMD
Executive Director
College of Dental Surgeons
of British Columbia

CDHA welcomes your comments and/or suggestions regarding issues raised in *Probe* or affecting the Dental Hygiene Profession. Send your letters to
**CHDA, Managing Editor — *Probe*,
1018 Merivale Rd, Ste 201,
Ottawa, ON, K1Z 6A5.**

We are also interested in receiving photos that can be used on the cover of *Probe* — the theme Colleagues from Coast to Coast seems to be a popular one and will continue into the New Year — so if you or one of your colleagues have an intriguing hobby and/or pastime that you want to share with your colleagues — send a photo to CHDA at the address noted above.



CDHA Recognizes Efforts of Departing Council Members

NEWS



In recognition of their contribution to the dental hygiene profession, CDHA honoured five departing council members and presented each with a wall plaque during the June Board Meeting held in Ottawa. Pictured from left to right are Laura Mowat — Chair of CDHA's Health Promotion Council (1991-93), Nancy Kirkpatrick — Chair of CDHA's Member Services Council (1991-93), Denis Côté — Member of CDHA's Practice & Regulation Council (1991-93), Nancy Kitchen — Member of CDHA's Health Promotion Council (1991-93) and Maxine Borowko — Member of CDHA's Practice & Regulation Council (1991-93). CDHA appreciates the many hours all of its volunteer board members contribute and invites all members to consider playing an active role in association activities and projects.



CDHA Past President Lorraine Boomhour (right) presents departing Executive Council Member/Past President Terry Mitchell with a wall plaque recognizing her contributions to CDHA.

Attend CDHA's North American Research Conference and Receive Patient Education Material — Free!

Oral-B recently introduced the Oral-B Atlas, patient education material that will help dental professionals demonstrate to their patients the various types and stages of dental disease along with the proper technique for home care. The Oral-B Atlas contains quality medical illustrations to provide anatomically correct and detailed visuals for dental professionals to use with their patients and does not include descriptive copy. Delegates who visit Oral-B's Commercial Exhibit while attending CDHA's fourth annual professional conference, 'An Exploration Into the Future — A North American Research Conference' being held in Niagara Falls October 15-17, 1993 will receive a complimentary copy of this unique educational tool!



CDHA Members Entitled to Discounted Prices

The American Dental Hygienists Association (ADHA) has agreed to extend the ADHA price discounts appearing in its 1994 Resource Catalogue to CDHA members for all materials appearing in the new ADHA Resource Catalogue. You will find a copy of the catalogue in the centre of this edition of *Probe*. When placing your order with ADHA, please be sure to identify yourself as a CDHA member, provide your CDHA membership number, and note that the ADHA membership cost is to apply to your order.



Linda Elkins, departing Executive Council member, accepts her award of recognition from CDHA Past President Lorraine Boomhour during the June Board Meeting held in Ottawa. Due to increased responsibilities and commitments Linda was unable to complete her term on Executive Council, her contributions will be greatly missed.

The Development of Comprehensive Practice and Education Standards for the Profession of Dental Hygiene — An Historical Overview of the Process

The impetus fueling developments in the dental hygiene profession is the intent to provide high quality dental hygiene care to the public. *Quality assurance* is the term used to describe processes or mechanisms put in place to ensure protection of public interest and it is also an essential component of self-regulation. Quality assurance encompasses three levels of standards:

1. **Basic Education** through the development of the following:
 - national educational standards
 - curriculum guidelines
 - theories and models of the profession
 - accreditation of educational programs
2. **Entry to Practice** through the development of the following:
 - national certification of individuals
 - provincial board examinations for licensure certification
 - registration, licensure and certification
3. **Practice and Continuing Competence** through the development of the following:
 - practice standards
 - code of ethics
 - mandatory continuing education
 - peer evaluation
 - mandatory testing

Some quality assurance mechanisms, such as the Code of Ethics and Clinical Practice Standards are already in place. Others, such as mandatory continuing education, are in place in some parts of the country only, while still others, i.e. national certification of individuals, are in the developmental stages. The Quality Assurance framework outlines the activities, courses of action, and future developments required for the professional growth and maturation of dental hygiene and the subsequent delivery of oral health care designed to serve the best interests of the public.

Several of the projects currently underway involve a number of organizations whose work has been undertaken for a variety of reasons. An overview of these

projects and how they relate to quality assurance (and to each other) is presented in *Figure 1*.

In **June 1991**, the Canadian Dental Association (CDA)'s Council on Education identified that the Dental Hygiene and Dental Assisting Competency Profiles, used to support the national accreditation process, required evaluation with respect to currency. The Association of Canadian Faculties of Dentistry (ACFD)'s Allied Dental Educators' Committee was chosen to address this need. In **June 1992** ACFD was funded by the Canadian Fund for Dental Education (CFDE) to conduct this evaluation in March 1993.

Concurrently, the Commission on Accreditation and the CDHA were investigating related areas of a national certification process and definition of national dental hygiene education standards. The CDHA national certification project has been underway since 1982. The CDHA definition of national education standards was launched in **January 1993** with the establishment of a task force.

In **February 1993** CDHA's National Certification Working Group recognized the inter-relatedness of these various projects and proposed that the stakeholder organizations work in collaboration. Consequently the **March 1993** workshop was expanded to include representatives from ACFD, CDHA, CDA, licensing bodies, the Commission on Dental Accreditation and allied dental educators from community colleges and universities.

Dental hygiene outcomes from this workshop identified the need for the dental hygiene profession to define itself and the need to revise and expand the clinical practice standards. These two steps were deemed essential building blocks for advancing the national certification process, for review of the Dental Hygiene Competency Profile, and for the development of national dental hygiene education standards. Plans were made to hold another workshop in Ottawa in June 1993, to be sponsored by CDHA and held in conjunction with its annual board session.

Representatives from all the stakeholder organizations attended the **June 1993** workshop with the addition of private and community dental health practitioners. The results of this workshop included a draft document, "Dental Hygiene: Definition and Scope", including a draft of revised practice standards reflecting all areas of responsibility of dental hygienists in practice. (Refer to the article entitled "Dental Hygiene 2005 — Creating the Future" for more details about the June 1993 workshop.) This work enabled the National Certification Working Group to propose the establishment of a National Dental Hygiene Certification Board (NDHCB) to oversee the planning and implementation of the national certification process.

What the Future Holds.....

The building blocks created at the June 1993 workshop laid the foundation for further work on all projects in **October 1993** during the CDHA Board Sessions, ACFD Educators Workshop and CDHA Research Conference. In addition, all stakeholder organizations agreed to reconvene in **June 1994** at the CDHA Professional Conference in Saskatoon. A workshop held in conjunction with the 1994 Professional Conference and sponsored by ACFD (with funding from CFDE) will again have all stakeholders working collaboratively.

It is anticipated that by June 1994 CDHA's Self-definition Document will have received board approval. This document will then become the springboard to a draft document of National Dental Hygiene Education Standards. It is also anticipated that by June 1994 the NDHCB will be developing policies.

By **June 1995**, at the CDHA Professional Conference in Halifax, it is expected that the national certification process will be operational and that the National Dental Hygiene Education Standards will be in final draft.

Special thanks to Bonnie Craig and Eleanor McIntyre for contributing this information.

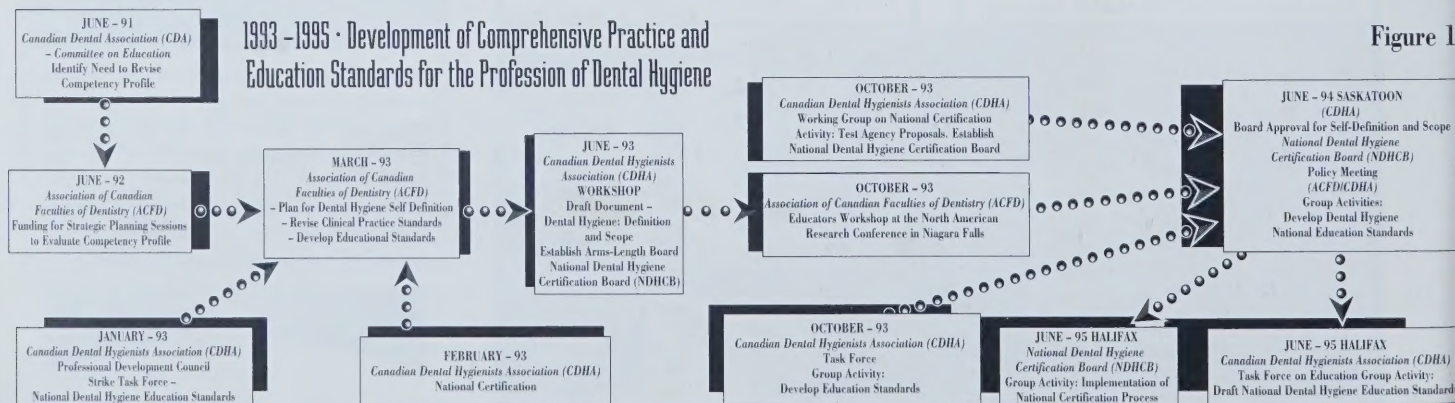


Figure 1

Dental Hygiene: 2005

Creating The Future

Participants of a CDHA-sponsored workshop held in Ottawa in June gathered to clarify and define the vision of dental hygiene for the year 2005. Their efforts over the three-day period focused on the development of a professional self-definition and the conducting of a comprehensive review of the profession's current clinical practice standards. The result was the development of a draft document, "Dental Hygiene: Definition and Scope of Practice".

The workshop was led by certified management consultant Sheryl Feller who is also a registered dental hygienist. Sheryl was directly involved in dental hygiene education and clinical practice for eleven years and has continued her involvement with the profession for the last twelve years through consultation to Health & Welfare Canada, CDHA, various provincial groups, educational institutions and private practices.

The workshop participants represented a variety of dental hygiene interests: Bonnie Craig, co-chair of CDHA's Task Force on National Dental Hygiene Education Standards; Marnie Forgay, a member of CDA's Commission on Accreditation; Dianne Gallagher, a member of CDHA's National Certification Working Group; Wendy Halowski, a member of CDHA's National Certification Working Group; Giselle Johnson, a member of the Association of Canadian Faculties of Dentistry (ACFD) Suzanne Knox, a dental hygienist practicing in a community health setting; Dianne Landry, a dental hygienist currently working in private practice; Susan Matheson, a representative from the Commission on Accreditation; Eleanor McIntyre, co-chair of CDHA's Task Force on National Dental Hygiene Education Standards; Lynda Michelson, Chair of the Transition Council for the College of Dental Hygienists of Ontario (CDHO); Brenda Walker, the registrar of the Alberta Dental Hygienists' Association, and CDHA Executive Director Carol Matheson Worobey.

The participants agreed to use the dental hygienist's key responsibilities as the organizing framework for professional self-definition. That is, regardless of the practice setting, every dental hygienist has primary responsibilities other than the delivery of clinical care. The four additional responsibilities most dental hygienists assume, at one time or another, were identified as follows: health promotion, education, administration and research. Health promotion and education do overlap and whether they will be identified as distinct and separate responsibilities in the final document has not yet been determined.

Following the identification of the dimensions of dental hygiene practice, the workshop participants reviewed criteria, standards and competencies for each of the areas of responsibility. In essence the current clinical practice standards were transformed into **comprehensive** practice standards reflecting the newly identified areas of responsibilities.

Having developed a functional set of comprehensive standards, the initial stages of a validation process for the revised standards were set forth. Numerous validation strategies for the revised and expanded standards were explored, however further work on an acceptable validation process is anticipated in the near future.

The June workshop was the first of many steps in a unified and cohesive movement to set the stage for dental hygiene practice in the year 2005 and beyond. Working together and drawing all the elements and processes which contribute to quality assurance is the route CDHA is taking to achieve a comprehensive and solid base for the future of the dental hygiene profession.

The drafting of the document, *Dental Hygiene Definition and Scope*, will enhance and facilitate the national certification process, the development of national standards for dental hygiene education and the revision of *Standards of Dental Hygiene Practice*.

DENTAL HYGIENE PROFESSION 2005

PRACTICE AND CONTINUING COMPETENCE

- practice standards
- code of ethics
- management statement
- mandatory continuing education
- peer evaluation
- mandatory testing

ENTRY INTO PRACTICE

- licensure
- registration
- provincial board exam
- national certification

EDUCATION

- accreditation
- curriculum guidelines
- theories & models of care
- standards (educational/practice)

All the elements and procedures contributing to quality assurance are working together to set the stage for the future.

CDHA Member Gives Birth to Triplets — Two After Record 45-day Delay

CDHA extends congratulations to Joanne March of Kelowna, BC who made medical history in Vancouver in June when she delivered two triplets six weeks and three days after their premature brother. According to an article that appeared in the June 16th issue of *The Ottawa Citizen*, the 45-day delay between the

first baby's birth, and that of his siblings, exceeds a previous U.S. record by 11 days.



CDHA Thirtieth Annual Session — Business as Usual

The thirtieth annual session of the Canadian Dental Hygienists Association was held in Ottawa in mid-June. Numerous resolutions were passed and presented. Here, for your perusal, are a few of the key resolutions passed during the June session:

- A draft document outlining CDHA's proposed revision for its goals and objectives was passed. The goals and objectives were revised as follows:

- To promote quality dental hygiene practice through strategies which include comprehensive standards, continuing competency, research and national certification.
 - To maximize the professionalization of dental hygienists in Canada through partnership with members.
 - To facilitate access to care through a variety of strategies including the initiation of legislation that provides greater consumer and provider choice in the delivery of oral health care.
 - To promote the regulation of dental hygienists by the dental hygiene profession.
 - To increase awareness of the dental hygiene profession and the dental hygienists' role in health care.
- It was agreed that the goals, as set forth, would not be listed in order of priority as board members agreed that all the goals were of equal importance and value, and the association is to focus on achieving all of its goals through a collaborative approach.*

- An increase to CDHA's annual membership fees for 1993/94 received unanimous support. Members should note that CDHA's annual membership fee now **includes malpractice insurance coverage**. The new fee structure is as follows:

Active Member	\$100.00
Support Member	\$ 60.00
Associate Member	\$ 60.00
Student	\$ 45.00

- CDHA's Professional Development Council was allocated \$4,500 to contribute towards the development and activities of its Task Force on Dental Hygiene Education Standards for 2005. (Note that this Task Force has become a key player in the National Certification Process.)

- CDHA's Professional Development Council was allocated \$1,000 to revise and promote CDHA's Quality Assurance Workshop. (Members are sure to hear more about this exciting workshop in the future.)

- The Practice and Regulation Council was allocated \$30,000 in the 1993/94 budget for the development of a National Certification Examination.

Our Apologies

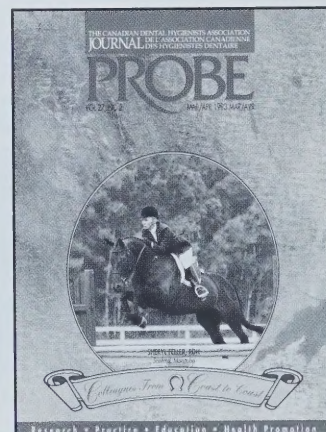
We neglected to provide a photo credit and details about Sheryl Feller, the CDHA Colleague from Sanford, Manitoba who graced the cover of *Probe's* March/April issue. Since Sheryl played a key role in CDHA's June meetings we thought this issue might be an appropriate one to let you know more about her. Sheryl was directly involved in dental hygiene education and clinical practice for eleven years and has continued her involvement with the profession for the last twelve years through consultation to Health & Welfare Canada, CDHA, various provincial groups, educational institutions and private practices. She earned her diploma in Dental Hygiene, a BA and an MBA from the University of Manitoba and was recently granted a Certified Management Consultant (CMC) designation by the Institute of Certified Management Consultants of Manitoba and now operates her own business SJB

Management Consultants from her home in Sanford.

Sheryl is also an avid horse lover. She says she has been "horse crazy" all her life, participating in 4-H and Pony Club as a teenager and showing Quarter Horses as a young adult. After several years of casual riding while her children were small, Sheryl pursued a childhood ambition to compete on the hunter/jumper circuit.

Her coaches, the Schweizers of Northfield Farms, spotted "Herschel" at Spruce Meadows in 1991 and thought he would be an excellent partner. The decision was clinched by his show name — Late Bloomer!

In 1992, the two Late Bloomers debuted at the Manitoba Royal Winter Fair, winning several ribbons in the Adult Amateur Hunter Division. They competed all season at Winnipeg Horsemen's



Club shows in Manitoba and ended the year as the Starter Hunter Champions.

Our sincere thanks to Margie Forbes, who photographed Sheryl, in action, and permitted us to use her work on the March/April cover of *Probe*.

CDHA Appoints Editorial Director

CDHA is pleased to announce the appointment of Dianne Landry, RDH, MDN, BA, BV/TEd, as the Editorial Director of *PROBE*. Dianne is currently living in Ottawa. She received her Diploma in Dental Hygiene in 1966 from the University of Manitoba, a Diploma in Dental Nursing in 1976 from the Wascana Institute of Applied Arts & Sciences, (Regina) a Bachelor of Arts (Psychology Major) from the University of Manitoba in 1986 and a Bachelor of Vocational/Technical Education in 1992 from the University of Regina. She has 27 years of experience working as a Dental

Hygienist/Therapist/Educator in the dental field and has instructed at the School of Dental Hygiene at the University of Manitoba and the Saskatchewan Institute of Applied Sciences and Technology.

Dianne will work closely with *Probe's* Scientific Editor, Marilyn Goulding and Managing Editor, Janice Edgar to coordinate the journal's content. We are pleased to welcome Dianne to *Probe's* production team and are confident her expertise will make a significant contribution to CDHA's scientific journal.



Are you an ESFJ, an ENFJ, an INFP...?

At CDHA's Annual Session held in Ottawa in June, board members could be heard describing themselves using four letter combinations either the same as, or similar to those noted above. That's because they were given an opportunity to determine their **Myers-Briggs Indicator Type (MBIT)** during a workshop delivered by Alex Campbell of Campbell Training and Consulting Inc.

What exactly is an ESFJ, ENFJ, INFP you ask? They are type indicators based on the Myers-Briggs personality type instrument (MBTI), an instrument that is designed to help individuals better understand key elements of their personality. The MBTI was developed by an American mother and daughter team, Katharine Briggs and Isabel Myers and it is based on the work of Carl G. Jung, the Swiss-psychiatrist who had studied people's behaviour for many years.

The MBTI provides a useful measure of personality by looking at eight personality preferences used by all people at different times. These eight preferences are organized into four bi-polar scales. When one completes the Indicator, the four preferences one chooses (one from each scale) are combined into what is called a "type".

The Myers-Briggs Type Indicator poses four basic questions, which in turn, assesses aspects of an individual's personality. The E/I scale determines the orientation of your energy source, that is, is your source of energy based on **extroversion (E)** or **introversion (I)**. Individuals who are more extroverted in nature are energized by the outer world, they focus on external things and people, are outgoing, tend to think out loud and are highly interactive. In contrast, those who are introverted gain energy from focusing within themselves, on thoughts and concepts. They are much more reflective in nature and have greater concentration skills.

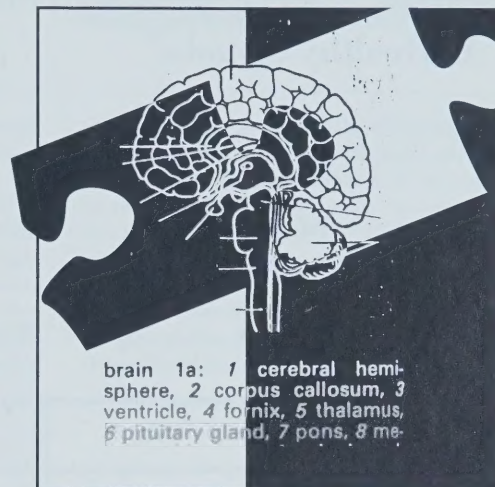
The S/N scale determines the orientation of your perception, that is, how you take in the information in your environment — you are either **sensing (S)** or

intuitive (N). Sensing individuals tend to be more fact and detail oriented. They are often considered practical and proceed at a steady pace, adopting a step-by-step approach to problem-solving situations. In contrast those who find themselves on the intuitive side of the scale focus on the theoretical, they may appear to be more erratic in their thought processes, skipping directions and thriving on change, variety, novelty and imagination.

The T/F scale determines how you make decisions, that is, your judgment orientation. Individuals are generally more oriented to either a **thinking (T)** system or a **feeling (F)** system. Thinkers tend to be more logical, focusing on principles, objectives and criteria. They may be considered more impersonal in nature and prone to analyzing and critiquing when asked to make a decision. On the other hand, feelers seek harmony and are generally more empathetic and compassionate in nature. There is a world dominated by the personal and humane circumstances with a very subjective approach to problem-solving.

The final scale, the J/P scale, identifies one's orientation to the world around oneself. Individuals are either **judgment (J)** or **perception (P)** based with respect to their orientation to the world. Judgment-oriented individuals are organized and value order, structure and established routines. They tend to be very settled, decisive and task-oriented. Perception-oriented individuals are more flexible in nature. These individuals tend to "go with the flow", act spontaneously, remain open-ended and are better able to adapt to whatever comes along.

Some interesting data was obtained during the June workshop, ESFJ and ENFJ were the most popular categories, with ISFJ and ISTF following close behind. These results seem to reflect the results of a similar survey conducted at the University of Manitoba on



brain 1a: 1 cerebral hemisphere, 2 corpus callosum, 3 ventricle, 4 fornix, 5 thalamus, 6 pituitary gland, 7 pons, 8 medulla

its First Year Dental Hygiene Students (1985-1987) who overwhelmingly fell into the IFSJ and ESFJ categories, which suggests that there may, in fact, be a link between your personality type and your suitability to a particular career and/or profession. In studies conducted in the United States, dental hygiene students were also discovered to be more E-oriented in general, typically sensing as opposed to intuitive in their approach to life, a striking majority were also found to be FS in their perception and judgment type.

If you want to learn more about the MBTI personality indicator refer to September's Book of the Month suggestion. It was recommended by the workshop facilitator, Alex Campbell and may be useful in helping you recognize and work with the personalities surrounding you either at home or in the workplace.

CDHA's 5th Annual Professional Conference
June 17-19, 1994 • Saskatoon, Saskatchewan

SHARPEN YOUR PROFESSIONAL EDGE

"A Question of Conscience – A Matter of Choice"

CONFERENCES ARE FOR SHARING...

Plan a Class Reunion for next June in Saskatoon – in conjunction with CDHA's 5th Annual Professional Conference.

If you are interested in planning a reunion for your former classmates and you are a graduate from one of Saskatchewan's dental hygiene programs, call Noel Selinger at (306) 584-7339 or write to Noel at 14 Langley Cres., Regina, SK S4S 2R3

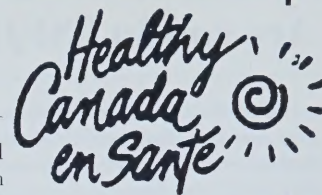
Any other individuals interested in organizing a class reunion during the 1994 Conference are asked to contact Janice Edgar at CDHA's Central Office, 1-800-267-5235.



CDHA Member Receives Award of Merit from Canadian Dental Association

Patricia Johnson, a CDHA life member and past president of the Canadian Dental Hygienists Association (1969-70), was awarded a Certificate of Merit by the Canadian Dental Association at the CDA's President's Dinner held in Ottawa in September. CDA's Certificates of Merit recognize any special service at any level of dentistry within the country. In general, it is reserved for dentists or other persons who have given at least one full term of service in such areas as councils/committees of the association, or long standing service at the corporate or specialty society level. The award was presented to Pat in recognition of her valuable contribution to CDA's now defunct Professional Resource Utilization Committee (PRUC) Committee, a committee which Pat sat on for three years.

CDHA Joins Other Health Professionals in Efforts to Build A "Healthy Canada"



Healthy Canada/Canada en santé is a call to action — a call for all Canadians to be more actively involved in their own health, the health of their families and communities, and in their health care system. In May, CDHA Executive Director, Carol Worobey joined other leaders in the health field, including representatives from various non-government organizations, health professionals, the education community, the private sector and youth to celebrate Canada Health Day and the launching of its

theme for the year: "Caring about health...everyone's responsibility."

Healthy Canada affirms that Canadians have the ability to create a revitalized health system — one that balances efficiency with compassion; individual and community responsibility with government and institutional accountability; and attention to health care with an increased emphasis upon health promotion, health protection, and illness and injury

prevention — all principles which CDHA strongly advocates. CDHA also agrees with Canadian Hospital Association President, Carol Clemenhagen, who says that a true partnership exists between consumers, health care facilities and agencies in communities across Canada and that together we share a responsibility and a vision for improving the health and well-being of Canadians.

Canadian Society of Public Health Dentists (CSPHD) Opens Membership to Hygienists and Other Dental Health Care Professionals

At the recent CSPHD annual meeting held in Toronto, two motions were carried by a large majority of the members present which have considerably altered the membership requirements of the Society.

The motions involved the opening up of CSPHD membership to other persons in the health care system who have significant interest in community dental health. This decision of CSPHD members basically puts to rest an issue which has been debated by the Society for many years.

The change makes the Society more similar to its U.S. counterpart, the American Association of Public Health Dentistry (AAPHD), which opened up its membership in 1977. (There are currently just under 800 members in the AAPHD, and approximately 150 of AAPHD's members are dental hygienists.) Although associate members of CSPHD will not hold office, they will, as with active members, have full voting rights on Society issues.

This change now allows members of CSPHD the opportunity to invite their co-workers and colleagues to become associate members of the Society. The Society stated that the decision was made because its members recognized that it is imperative that health care professionals work together to form a strong cohesive group of professionals dedicated to the enhancement of community dentistry ideals and objectives in these times of dental program reduction and fiscal restraint.

Membership in CSPHD entitles dental hygienists, dental nurses, dental therapists, dental assistants and dental health educators to the following benefits:

- membership in the official national voice representing dental public health issues;
- three copies of the Journal of Community Dentistry each year;
- membership in a Society with specific research objectives to be achieved over the next two years;
- access to peers and colleagues with similar interests and objectives through an annual scientific session and business meeting held prior to the CDA Annual Dental Meeting;
- representation through the Society's Executive at the CDA Board/Management level.



Since the dental profession, as a whole, is heading into some clearly difficult times, members of CSPHD feel it is vital to form a strong group which can represent the dental professional interests while providing each individual with the necessary academic and research information. Through a board and stimulating spectrum of membership, CSPHD believes it will be able to provide the dental

profession with this vehicle.

In the 1992/93 membership year, there were 82 active members in the Canadian Society of Public Health Dentistry, all of whom were public health dentists. For more information on how you can become a member of the Canadian Society of Public Health contact Dr. Euan Swan at (613) 996-5908. Application forms are also available through CDHA's Central Office, call 1-800-267-5235.

Submitted by: Dr. Peter Cooney, President, CSPHD

Canadian Dietetic Association and American Dietetic Association Develop First Joint Position Addressing Nutrition and Physical Fitness

The Canadian Dietetic Association (CDA) and the American Dietetic Association (ADA) have jointly developed and adopted a position that recognizes that nutrition and physical fitness are beneficial to everyone's health.



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DIETETIC ASSOCIATION
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CDA and ADA say: "It is the position of the Canadian Dietetic Association and The American Dietetic Association to support access to accurate and appropriate information that explains the interrelationships between exercise and nutrition, reinforces the important role of nutrition, and encourages appropriate food choices to achieve optimal physical fitness and athletic performance."

The position is the first to be developed under an agreement signed by the two organizations last October.

Percutaneous Injuries and the Concern of HIV Transmission

By:
Julie Ann Miller, RDH

It only takes the briefest part of a second, one fraction of a slip of the finger, the slightest contact, and you've done it... you've suffered a percutaneous injury from the tip of an unsterile instrument.

Only a few short years ago, such an accident would pass by barely noticed, and you certainly wouldn't spend precious time dwelling on the possible consequences. Today, with the AIDS virus rapidly becoming the most feared pandemic disease of all time, the seconds following such an accident are filled with absolute fear and dread. Any educated, well-informed person knows that the possibilities of contracting the disease in such a manner are remote to nil, but the instant the instrument pierces through the skin all such reasonable thoughts flee. The Center for Disease Control (CDC) estimates that, at present, about 1 in 600 adult females and 1 in 100 adult males are positive for the human immunodeficiency virus (HIV), and the immediate reaction is to wonder whether the patient treated with the injury-causing instrument fits into that category.¹



JULIE ANN MILLER, RDH

- 2) any febrile illness occurring in the twelve weeks following the exposure should be reported and evaluated by the health-care worker's physician.
- 3) the exposed worker should undergo serological re-testing at 6 weeks, 12 weeks, and 6 months after the initial exposure, assuming s/he tested negative initially.
- 4) s/he should seek post-test counseling to alleviate anxiety.²

In the event that the source patient refuses to be tested, or cannot be identified, the above steps should still be carried out, with post-test treatment being individualized according to the circumstances.

If the source patient is tested and found to be seronegative for HIV, baseline testing should be performed on the health-care worker, with

follow-up testing being performed if deemed necessary or advisable by her/his physician.

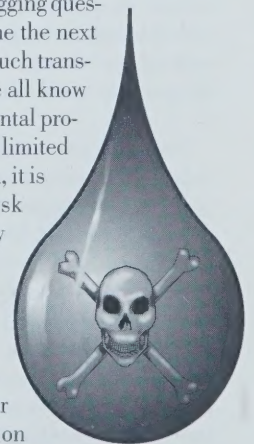
"It only takes the briefest part of a second, one fraction of a slip of the finger, the slightest contact, and you've done it..."

Immediately upon suffering an accidental injury in which any exposure to blood occurs, the area should be washed thoroughly with soap and water. The incident should be accurately documented in writing, noting the circumstances leading to the exposure, the amount and type of body fluid, and the type of exposure (percutaneous or mucosal).²

The CDC recommends that the source patient undergo HIV testing as soon after the incident as possible, however the patient must consent to such testing. In the event that the individual from whom exposure occurred has AIDS, or tests positive for HIV infection, the following steps should be taken by the health-care worker sustaining the injury:

- 1) s/he should be evaluated clinically and undergo serological testing for evidence of HIV antibodies immediately in order to obtain baseline data; obviously in the unlikely event that s/he does contract the infection from the patient, s/he wouldn't show up positive at this point.

These recommendations, set forth by the CDC, seem so very straightforward and sensible...that is, until such a time that an injury really is received. Suddenly implications that were never even considered begin to spring forth, adding to the confusion and fear. In asking a patient to be tested to determine their HIV status, you are opening so many doors that, upon consideration, may seem better left closed. If indeed the patient is found to be HIV positive, there will always be that nagging question at the back of your mind: will you become the next 'victim' on the list of the forty known cases of such transmission of HIV from patient to clinician?³ We all know that the virus is fragile, and with millions of dental procedures being performed every day and such a limited number of reported cases of such transmission, it is evident that the risk is minuscule. It is a risk nonetheless, and an unfamiliar, involuntary one at that. Perhaps the magnitude of fear is increased so greatly because the risk is such an unfamiliar one; we all know that we run the risk of injury or death every time we get into an automobile, yet somehow this knowledge doesn't cause as much concern as the far less likely event of contracting HIV infection from a patient during a dental procedure. The threat of HIV is invisible and the effects of infection are delayed, making the risk of contraction especially ominous. Once infected, you have



"The tragedy of the well publicized case of a dentist infecting five patients with HIV in a Florida office has understandably alarmed the public, who have begun an outcry regarding their right to safe health care."

ultimately been handed a death sentence and there is no control over the outcome. While these concerns are indeed very real and valid, we must take care not to let a remote possibility become an irrational fear.

While our first instinct after an injury is usually to fear for our own safety, the flip side of the situation must be considered with equal concern. Upon being told that you have injured yourself while working within their mouth, a patient has every right to question whether your blood came into contact with his oral cavity, and to wonder about your HIV status. The tragedy of the well publicized case of a dentist infecting five patients with HIV in a Florida office has understandably alarmed the public, who have begun an outcry regarding their right to safe health care. We cannot brush the patients' concern off as 'unfounded hysteria', instead we need to acknowledge their fears. "Perceptions of risk will not be changed merely by reassuring patients that a risk is low or by comparing it with other risks; comparisons that appear to trivialize a risk are counterproductive."⁴

At this time, the CDC is aware of 40 cases of HIV transmission from patient to clinician... thirty-five more cases than that of the infection being carried from clinician to patient.⁵ Obviously we can see that the risk is greater to us, as health-care workers, but this is little consolation to the patient. If a patient feels that we have presented a significant risk to them, we should certainly feel an ethical obligation to present them with the facts of our HIV status, knowing we would want them to do the same for us. A bill was introduced to the US Senate in July of 1991 which, if passed, would require all health-care workers having any physical contact with patients to disclose if they are seropositive to the HIV anti-bodies. Obviously public opinion strongly supports such an issue, however it is one that is still surrounded by much controversy. Realistically, such measures can offer no more than a false sense of security to patients because, due to the incubation period of the virus, it is possible to test negative several or even months after infection has actually occurred. Keeping moral and ethical issues in mind, we must remain committed to protecting our patients' health; when they visit us seeking professional dental health care, we should hope that the last thing on their mind will be the fear of contracting AIDS.

Obviously, we must all practice with utmost care in order to avoid percutaneous injuries, but unfortunately even with scrupulous care such accidents will happen. In our society, AIDS has the distinction of being the most feared and dreaded disease, and no one can blame the feelings of fear and trepidation that grip a person upon first recognition of such an injury — they fear they will be the next to fall prey to the threatening disease. There is still much to be learned about AIDS, but the one thing that everyone does know is that the end result is certain death. We cannot pretend that this disease will be easily defeated, nor can we ignore its rising incidence and failure to discriminate. However, we must not let the fear of AIDS become an irrational one; with proper infection control and responsible ethics the need for concern can be kept to a minimum. We cannot expect to live in a risk-free world, but we can strive to minimize the risks in our profession.

I am striving daily to keep everything in perspective, and I am beginning to become acclimatized to the reality that, unsettling though it may be, it is virtually impossible to carry on in my chosen profession without a minimal amount of risk; such an amount of risk pales in comparison with the tremendous satisfaction and the rewards I continually discover in the health-care field.

Footnotes and References

1. Perocchi, L. AIDS: everyone's at risk. **Wildcat Crier** 1(6):1, 1992.
2. Guidelines for Prevention of Transmission of HIV and HBV to Health-Care and Public Safety Workers. **Publication No. 89-107**: Cincinnati, 1989.
3. Cohen, J. Unkindest cut. **The New Republic** 19: 18-19, 1991.
4. Lo, B. and R. Steinbrook. Health care workers infected with the human immunodeficiency virus: the next steps. **Journal of the American Medical Association** 267(8): 1100-1104, 1992.
5. McCarrick, P.M. AIDS: update for ethical and legal issues. **Reference Services Review** 19(2): 59-75, 1991.
6. Breo, D.L. The slippery slope: handling HIV-infected health workers. **Journal of the American Medical Association** 264(11): 1464-1466, 1990.
7. Neidle, E.A. A matter of policy. **Journal of the American Dental Association** 122: 45-48, 1991.
8. Hopp, J. and E. Rogers. AIDS and the Allied Health Professions. F.A. Davis, Philadelphia, 1989.

Julie Ann Miller attended Westbrook College in Portland, Maine, where she graduated in 1992 with an associate in science degreee in dental hygiene. She currently resides in Mississauga and works full-time in private practice in Cambridge, Ontario.

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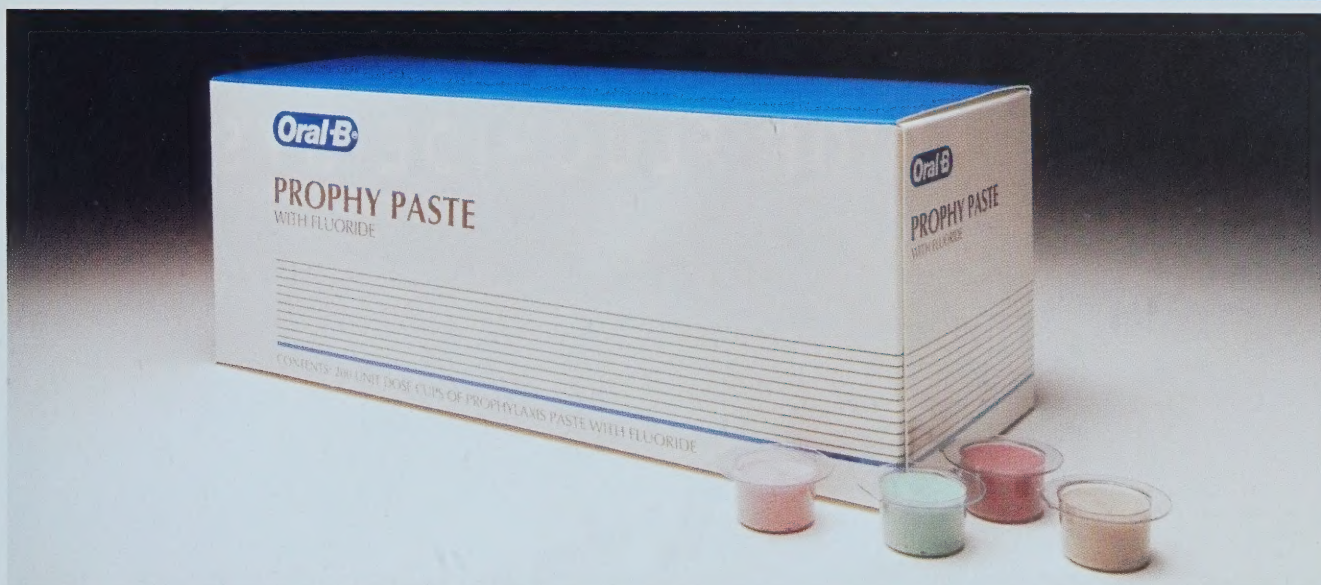
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Journal of the European Organization for
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References 1. Stookey GK et al. *Caries Research*, June 1993.
Applies for equal total fluoride levels versus SMFP.
2. Procter & Gamble, data on file based on mathematical model In:
Kingman A. *Caries Research* 1993; in press.
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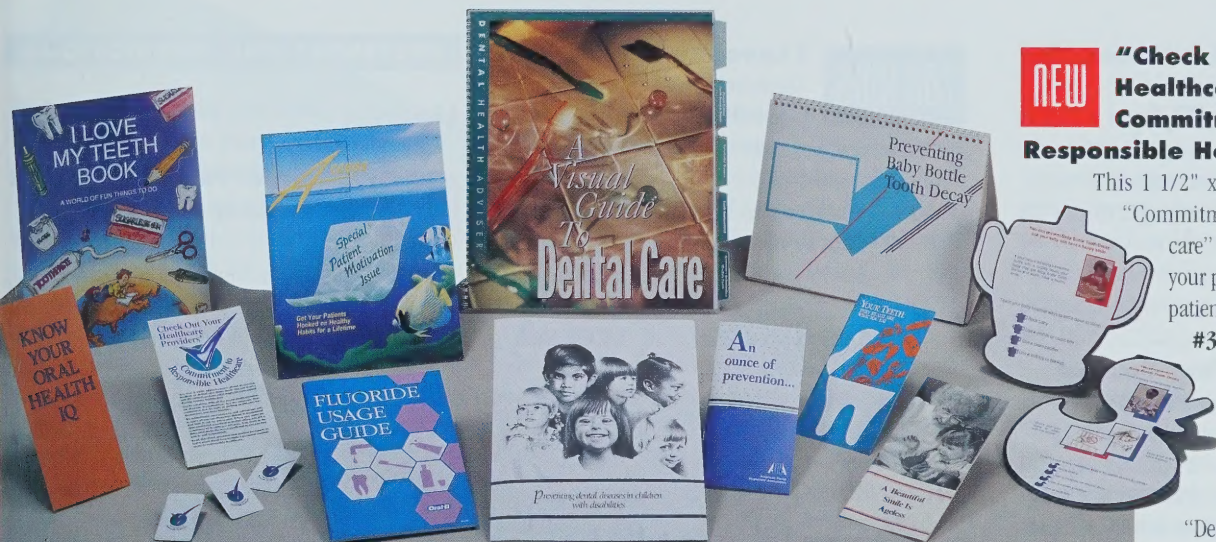


93-94 Product Catalog

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Chairside Reference Patient/Consumer Education



NEW "Check Out Your Healthcare Providers' Commitment to Responsible Healthcare" stickers

This 1 1/2" x 2 1/2" sticker features the "Commitment to Responsible Healthcare" logo and is a great way to let your patients know you care. Affix to patient invoices, recall cards, etc.

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#3069

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Similar to an index card file, this excellent source brings practical infection control information to the clinician's fingertips. Stored within an acrylic card file, 63 laminated cards, 4" x 6" in size, cover 24 topics including Glossary of OSHA Terms, Disease Transmission, and Elements of An Infection Control Program. Each topic is color-coded for easy subject selection and replacement. A must for every clinical setting.

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This 6" x 9" booklet examines the caries process, fluoride as a caries-preventive agent, and fluoride preparations for both office and home therapies. Quick reference charts, before and after photographs, and commonly asked questions and answers make this a terrific, hands-on resource.

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GREATER AWARENESS...

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An 8 1/2" x 11" instructional flip chart, with 15 pages of colorful illustrations and photographs, explains the dangers of bedtime baby bottle use and offers caregivers healthier habits. Includes two pads (25 sheets each) of giveaway instructions. Perfect for public health settings and appropriate for all literacy levels.

#3158 Flip chart and 2 pads of instructions.....\$24.00

NEW "Check Out Your Healthcare Providers' Commitment to Responsible Healthcare"

This brochure educates consumers about proper infection control during their oral healthcare treatment and answers questions about the prevention of disease transmission.

#3042 First quantity of 10FREE
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Packs of 100.....\$25.00 per pack
Packs of 500.....\$100.00 per pack
Packs of 1,000...\$150.00 per pack

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"Answers to Your Questions about AIDS" is a 4-page fact sheet designed to answer questions that apprehensive consumers might ask about HIV, AIDS, and the risk of being infected in the oral healthcare setting. Developed by infection control and HIV experts, it is ideal for patient and consumer distribution.

#2763 500+ copies.....\$.50 each
100-499 copies.....\$.75 each
25-99 copies.....\$.95 each
1-24 copies.....\$2.00 each

Know Your Oral Health IQ

This brochure features an informative oral health quiz and includes educational information on plaque, periodontitis, tartar, tooth decay, and gingivitis.

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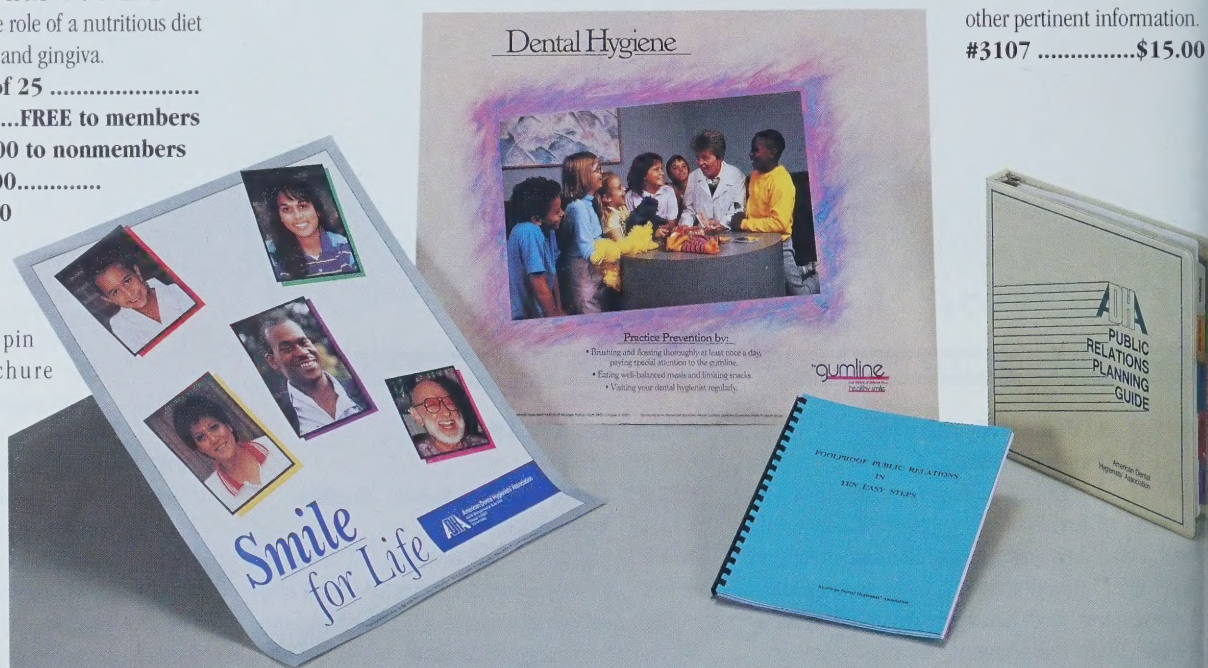
This booklet provides tips on general oral health including instructions on proper brushing and flossing. Useful as a patient hand-out and for consumer-oriented activities such as health fairs.

#2348 Multiples of 25\$6.50 per 25
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FOR KIDS I Love My Teeth

This coloring book uses games and puzzles to reinforce good oral healthcare practices and is a delightful way to involve younger patients.

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ARC Oral Health Care Packet

This 10-page folder features at-home tips and techniques on oral care for dental professionals and caretakers of the disabled. Developed by the Association of Retarded Citizens (ARC), the Academy of Dentistry for the Handicapped, and the ADHA, sponsorship was provided by the Johnson & Johnson Professional Dental Care Company.

#2931 25+ copies.....\$1.25 each
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PRESENTATIONS/PROMOTIONS

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Presentations/Promotions Continuing Education

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#2933 Booklet\$8.00
Slide.....\$15.00
+ \$50 refundable deposit (rental)

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This 72-page research report offers the results of a study that profiles a cross-sectional sample of non-practicing dental hygienists to determine their reasons for leaving and the factors that could facilitate their re-entry. The research report provides valuable insight and specific recommendations for tapping into this potential source of manpower.

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Designed to complement the career recruitment video, this brochure presents dental hygiene as a profession of opportunity and widespread appeal. Excellent for career fairs and NDHA and ADHA constituent and component activities.

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PLUS

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The Second Conference on Dental
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Family Violence: A Problem with Relevance for the Dental Hygienist

By:
Marg Wilson, RDH, BEd

Introduction

The objective of this article is to raise your awareness of an unpleasant reality within Canadian society: Family Violence; and to explore the dental hygienists' role in dealing with victims of abuse. Most of the information contained in this paper was derived from the FACT SHEETS available through Health and Welfare Canada's National Clearinghouse on Family Violence*. These Health and Welfare FACT SHEETS are very informative and I would recommend that you obtain copies, to share and discuss with your co-workers and to leave in your office waiting room. The more people are aware of the problem, perhaps the more solutions will be generated.

Family violence affects us all. It affects those directly involved in a number of hurtful and long-lasting ways that range from physical and psychological scars to death. It also affects those indirectly involved because coping with the devastating effects of family violence can drain the resources of the entire community.

This is not just another societal problem with no direct relevance for the dental hygienist. Dental hygienists, as primary health providers, are in a position to recognize some of the consequences of family violence. With recognition comes a legal responsibility to report abuse and a moral responsibility to improve the health of victims.

The true prevalence of family violence is unknown for a number of reasons. Sometimes a failure to acknowledge the reality of abuse leads to non-reporting. Since family interactions are considered private, there is a reluctance to invade the privacy of others and a hesitation to become involved. Also, the abuse may go undetected. For example, during a 30 minute dental appointment, the hygienist may be so focused on the task at hand that she/he fails to notice bruising behind the ears of a patient. This failure to recognize physical injury can result in non-reporting. Voluntary reporting is further reduced by the shame, secrecy and emotional pain associated with violence against a family member. Then too, our health care system is structured such that victims can gain access to care from any number of different professionals and thus a true profile usually only surfaces when extreme cases present to a health facility.

Nonetheless, statistics from Health and Welfare Canada are alarming. A survey done in the United States (1988) revealed that nearly



MARG WILSON, RDH, BEd

1.5 million children are severely abused each year¹; estimates indicate that one in every ten women in Canada are abused by a partner each year², in 1988, 15% of all Canadian homicide victims were women murdered by their male partners³, and a 1989 study reports approximately 98,000 Canadian seniors living in private dwellings have been abused⁴.

Family violence can take many forms including physical, sexual, emotional, financial abuse, and neglect. Since wives, children, and elders are the primary victims of abuse within families, these three categories are used to describe the most common forms of family violence. Abuse is not confined to any particular social class, rather, it cuts across all ethnic, religious, social, and economic backgrounds.

As health care professionals, dental hygienists do not have the power to stop the abuse that occurs among families in this country, but they can make a difference if they recognize, record, and report the cases observed.

Physical Abuse

Physical abuse is generally defined as non-accidental injury as a consequence of the deliberate application of force. Physical abuse or assault is potentially fatal. Head, neck, and intra oral areas account for the majority of physical abuse sites in children⁵, while back and head injuries, loss of hearing, and impaired eyesight have been reported for women⁶. The accessibility of head and neck make these areas common targets of physical abuse. Specifically, the most frequent orofacial injuries are fractured teeth, laceration of the labial frenula, missing or displaced teeth, fractures of the maxilla and mandible and bruised or scarred lips and ears⁷.

Dentists are most commonly the first persons to see acute physical trauma in the dental office. However, the dental hygienist is also in a position to see evidence of trauma for which there may be no reasonable explanation. During a routine extra and intra oral examination, hygienists may be able to detect lesions, abrasions or other abnormalities that could be the result of abuse. For example, when assessing the patient during palpation of the auricular and parotid lymph nodes the hygienist may detect bruising around the ears, palpation during examination of the temporalis muscle may uncover skull fractures, and a routine examination of the intra oral soft tissues may uncover frenum tears and bruising.

Upon recognition of an abnormal clinical picture, the dental hygienist should gently question the patient. This history taking will help determine whether the victim has been similarly injured on other occasions, or if the observed condition is a consequence of a systemic disorder. In addition, the medical history will help to determine if there are discrepancies between the patient's information and the clinical picture. Examples of discrepancies that should be recorded by the dental hygienist may include old bruises, lacerations, and scars reported as recent injuries, changes in the story told by the parent from one appointment to another, a vagueness about accident details, and the presence of burn or bite marks with no expressed concern by the caregiver.

It is imperative that the dental hygienist document any abnormalities that are found using all possible means including written descriptions, radiographs and photographs. Specifically, the shape, location, size, color, and pattern of any lesion or abnormality that is found must be recorded. Abnormalities with a distinctive pattern such as burns, bite marks the shape of a hand or other identifiable objects are very important findings.

While, potentially, the most serious cases of child abuse involve preschoolers and infants, children of all ages suffer accidental bruises. For example, preschoolers learning to walk can bruise after bumping into objects that are in their path. The elderly can also suffer from accidental bruising as several medical conditions can result in loss of balance. Notwithstanding, any orofacial bruising deserves an investigative question and an appropriate chart entry.

Staff turnovers are a reality for every dental office but chart entries remain permanent records of the patient's health status. Documentation within a chart is admissible as evidence should an abuse case go to court.

Sexual Abuse

Sexual abuse, for a child, occurs when a child is used for the sexual gratification of an adult or an adolescent. Children are most vulnerable to sexual abuse in the pre-adolescent stage between the ages of 8 to 12⁹. Child sexual abuse is a criminal offence in Canada. For women and the elderly, the definition of sexual abuse more closely resembles sexual assault.

Sexual abuse recognition is difficult for the dental hygienist. Gonorrhea, syphilis, and herpes proctitis can have oral manifestations, but because these lesions are rare, dental hygienists may lack familiarity with their clinical appearances. If in doubt, the hygienist should consult with the dentist and collect samples for laboratory testing which would positively identify the lesion.

Besides these lesions, there are other clinical symptoms of sexual abuse. Small children who have been forced to perform oral sex with an adult could present with frenum tears, petechiae (pin-point hemorrhages), and/or complaints of a sore throat. Children who have been so abused may also demonstrate an extreme reluctance (there may even be a hysterical response)⁹ to an

"...any tears, bruising, and/or petechiae observed inside the mouth, as well as any extreme patient reaction to a routine procedure should be noted in the chart."

attempt to insert anything into their mouth (eg. fluoride tray). Oral penetration can also cause vomiting which can lead to decalcification of dental tissues. Again, any tears, bruising, and/or petechiae observed inside the mouth, as well as any extreme patient reaction to a routine procedure should be noted in the chart.

Emotional Abuse

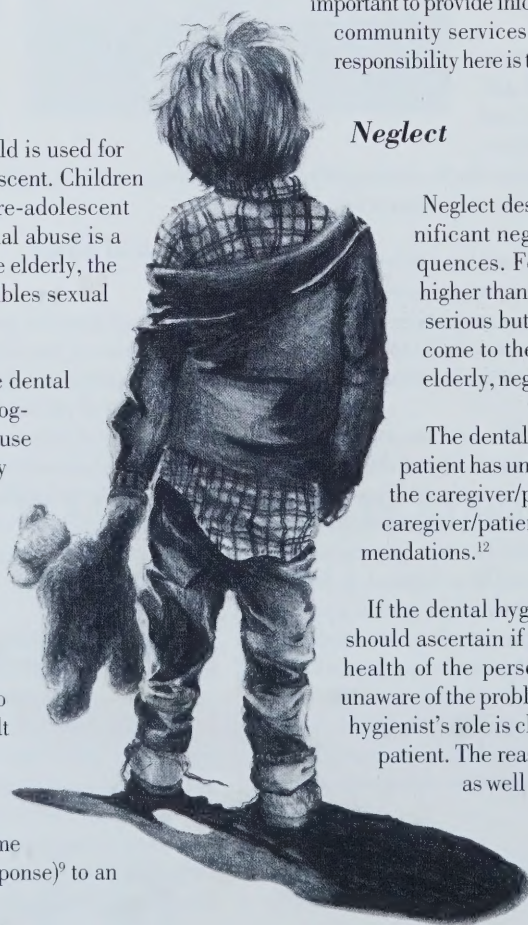
Emotional abuse involves persistent attacks on a person's sense of self. This is a very difficult area for the dental hygienist to detect mainly because of the episodic nature of dentistry and the short length of dental appointments. The interaction observed between a child and the accompanying caregiver during the half hour office visit may be profoundly affected by the child's and/or the adult's personal dental phobias. You may hear a verbal exchange between a child and an adult that you feel is abusive but that interaction may not represent chronic emotionally abusive behaviour. Or what of the interaction between an elderly patient and the caregiver? What if the caregiver berates the elderly person and doesn't allow his/her participation in decision making? The hygienist may feel that the elderly patient is quite capable of providing informed consent, in which case he/she could ask the caregiver to sit in the waiting room. These patients may never return to your office for care so it is important to provide information and discuss treatment options and community services available. The dental hygienists' moral responsibility here is to treat all patients with respect¹⁰.

Neglect

Neglect describes acts of omission which cause significant negative emotional and/or physical consequences. For children, the incidence of neglect is higher than that of physical abuse¹¹ and is equally as serious but physical assault cases are more likely to come to the attention of public authorities. For the elderly, neglect can lead to other types of abuse.

The dental hygienist should suspect neglect when a patient has untreated caries, a chronic disease for which the caregiver/patient has not sought treatment, or if the caregiver/patient repeatedly ignores health care recommendations.¹²

If the dental hygienist suspects physical neglect he/she should ascertain if the caregiver is wilfully endangering the health of the person or if the neglect results from being unaware of the problem. If ignorance is the problem, the dental hygienist's role is clear — he/she must educate the caregiver/patient. The reasons for treatment, treatment alternatives, as well as the consequences of no treatment, must be given to the patient or caregiver in a truthful, understandable and sensitive way.¹³



(Illustration by Kathleen Cassidy, Nancy Poirier Type Services)

Dentistry in the 1990's involves a fee for services provided. Not all Canadians share equal access to dental care and to dental insurance to cover this treatment. Perhaps neglect is not a question of being unwilling to obtain treatment, rather being financially unable to do so. Dental hygienists could be most helpful if they were aware of alternative sources of care and funding within their community.

Financial Abuse

This category of abuse is the most prevalent type of abuse among Canadian elderly¹⁴ and involves the misuse of money or property. It is often perpetrated by a family member or guardian. The dental hygienist is not in a strong position to recognize this kind of abuse. An unpaid dental bill may be a symptom of forgetfulness rather than an indicator of material abuse.

Reporting

If, after documenting a thorough medical history and clinical findings, a dental hygienist has reasonable and probable grounds to suspect abuse, he/she should act. The first step is to have the documentation verified. The presence of a witness to cosign entries made in a chart adds support to personal observations. The second step is to gently inform the patient and/or caregiver of your professional concern with the noted clinical findings. This is not to suggest a confrontation, rather, is recommended as a course of action to ensure that all parties are informed. For example, a caregiver is informed that you are concerned with a particular lesion and wish to re-check it in a week.

In cases of child abuse, it is the law to report concerns to the child welfare agency, provincial/territorial social services department or police force. The dental hygienist is protected from any kind of legal action provided the reporting is not done maliciously.

For abuse toward women and older adults, the path of action pursued by the dental hygienist is not quite as clear. There is still an expectation to document any suspicious lesions or abrasions found. However, as adults, they are presumed competent and capable of making decisions for themselves. A dental hygienist can help these victims the most by knowing what support services are available at the community level, learning more about the needs and experiences of abused individuals and by establishing a maltreatment protocol for the office.¹⁵

Summary

Family violence is a societal reality that affects us all. Dental hygienists should be aware that the primary victims of abuse are women, children and older adults. The hygienist has a role to play in recognizing the clinical manifestations of abuse because the majority of physical injuries sustained involve the head and neck. Upon recognition and after clear and concise documentation in the chart, dental hygienists should ACT. The law clearly states that reporting child abuse is mandatory for persons in positions of authority such as teachers, police officers and health care professionals, consequently, it is the legal responsibility of all hygienists. There is also moral responsibility to victims of abuse. The dental hygienist can initiate discussion on this topic at work and be instrumental in establishing office protocol to deal with recognized victims of abuse. Although efforts on the part of dental hygienists may not stop abuse within families, they truly can make a difference!

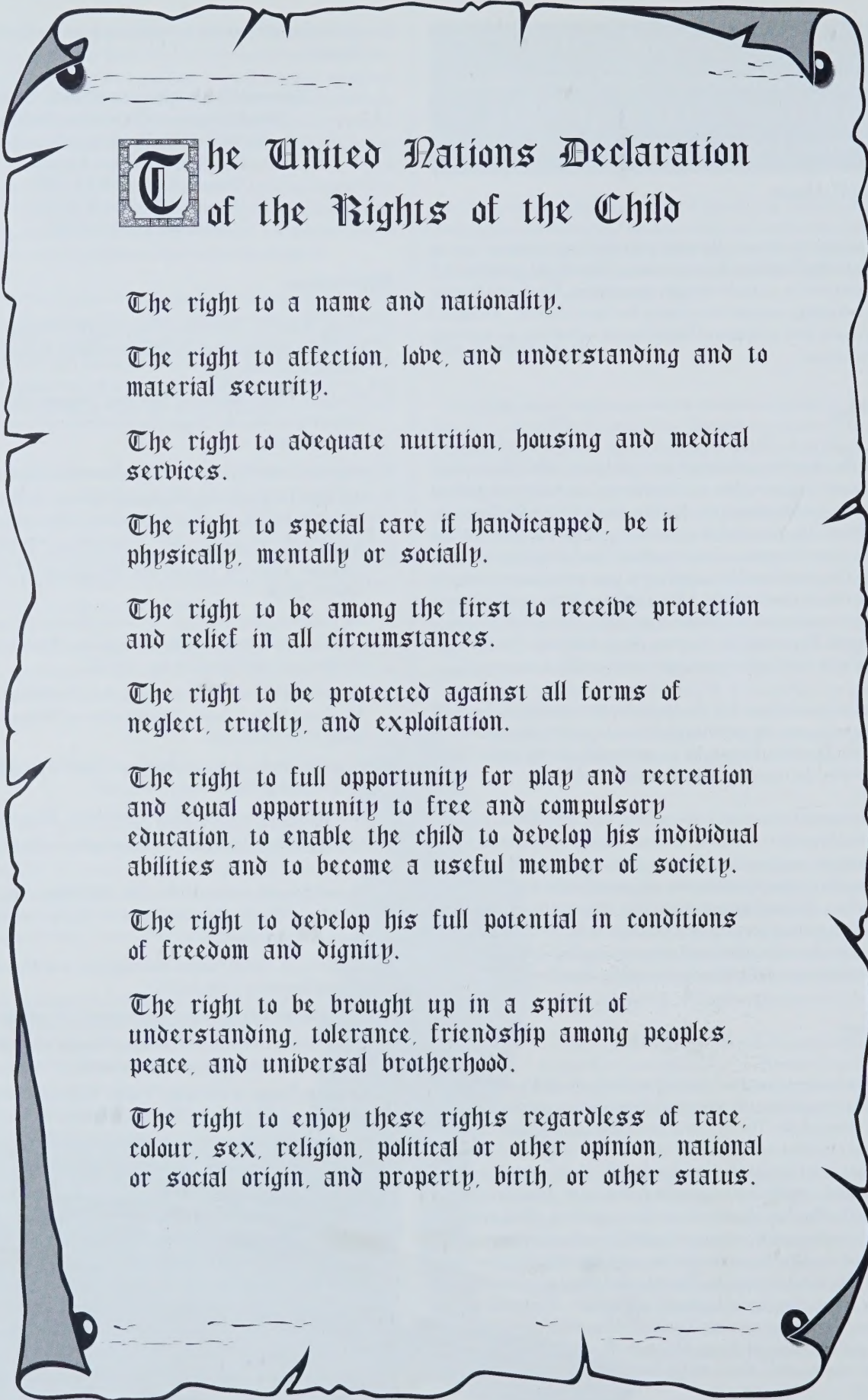
* For further information or publications on family violence issues, contact:

National Clearinghouse on Family Violence
Family Violence Prevention Division
Social Service Programs Branch
Health and Welfare Canada
Ottawa, Ontario K1A 1B5
Phone: 1-800-267-1291
Fax: (613) 941-8930

References

1. Straus, Murray A. and Gelles, Richard J. **How Violent are American Families?** Estimates from the National Family Violence Resurvey and Other studies. 1983, p. 26.
2. Macleod, Linda. **Battered But Not Beaten: Preventing Wife Battering in Canada.** Ottawa. Canadian Advisory Council on the Status of Women, 1987.
3. Canadian Centre for Justice Statistics, **Homicide Report, 1988.**
4. Podrichs, Elizabeth et al., **National Survey on the Abuse of the Elderly in Canada.** (Toronto: Ryerson Polytechnical Institute, 1990).
5. Becker, D.B., Needleman, H.L., and Kotelchuk, M. Child Abuse and Dentistry: Orofacial Trauma and Recognition by Dentists. **JADA** 1989;97, 24-28.
6. The Church Council on Justice and Corrections and the Canadian Council on Social Development, **Family Violence in a Patriarchal Culture: A Challenge to our Way of Living.** 1988:12.
7. Davis, G.R., Domoto, P.K., and Levy, R.L. The Dentist's Role in Child Abuse and Neglect. Issues, Identification and Management. **J. Dent. Child.** 1979; 46:185-192.
8. Finkelhor, David. **A Sourcebook on Child Sexual Abuse.** (Beverly Hills, Calif. Sage Publications, 1986), p. 64.
9. Personal interview with Alberta social worker, G. Kilgamon, 1993.
10. **Canadian Dental Hygienists' Association Code of Ethics** (1992), p. 4.
11. Wolock, Isabel and Horowitz, Bernard. **Child Maltreatment as a Social Problem: The Neglect of Neglect.** Ottawa: National Health and Welfare, October 1984, p. 9.
12. Giangregg, E. **Child Abuse: Recognition and Reporting Special Care in Dentistry.** 1986, 6:62-67.
13. **Canadian Dental Hygienists' Association Code of Ethics** (1992), p. 7.
14. Migus, Natalie I. **Health and Welfare Canada's Fact Sheet on Elder Abuse,** 1990. National Clearing House on Family Violence.
15. **Canadian Nurses Association: Family Violence Clinical Guidelines for Nurses,** 1992. 46 pp. National Clearing House on Family Violence.

Marg Wilson received her Diploma in Dental Hygiene from the University of Alberta's Dental Hygiene Program in 1971; she earned her BEd at the University of Alberta in 1981. She has worked in public health, private general practice and specialty practice (periodontics) for the past 22 years. She has taught part time at the University of Alberta for the past seventeen years. She is currently Associate Clinical Professor and Quality Assurance Coordinator at the Faculty of Dentistry at the University of Alberta.



he United Nations Declaration of the Rights of the Child

The right to a name and nationality.

The right to affection, love, and understanding and to material security.

The right to adequate nutrition, housing and medical services.

The right to special care if handicapped, be it physically, mentally or socially.

The right to be among the first to receive protection and relief in all circumstances.

The right to be protected against all forms of neglect, cruelty, and exploitation.

The right to full opportunity for play and recreation and equal opportunity to free and compulsory education, to enable the child to develop his individual abilities and to become a useful member of society.

The right to develop his full potential in conditions of freedom and dignity.

The right to be brought up in a spirit of understanding, tolerance, friendship among peoples, peace, and universal brotherhood.

The right to enjoy these rights regardless of race, colour, sex, religion, political or other opinion, national or social origin, and property, birth, or other status.

The Role of the Dental Hygienist in a Multicultural Society

Review of Literature 1988-1993

By:
Dorothy Cairns, RDH

Abstract

As Canada's population becomes increasingly more diverse, dental hygienists must face the challenge of providing culturally sensitive health care. This literature review provides a sample of cultural and professional beliefs/values, traditional oral hygiene practices and psycho-social determinants that can affect the delivery of dental health services. The paper concludes by addressing some of the personal, professional and research implications of multicultural diversity for the dental hygiene profession.

Introduction

The concept of providing individualized care to Canada's diverse immigrant population may seem new and intimidating to many dental hygienists. This review of a selection of Canadian, British and American literature from dentistry and other health professions published between 1988 and 1993, will explore some of the challenges. Most of the literature found on this subject was published by other health professions with the majority being published outside of Canada. While understanding that generalizations cannot be made from data collected outside of this country, the literature was reviewed for concepts, ideas, and information that would be of significance for Canadian hygienists.

There has been little change in the percentage of immigrant population in Canada since 1941. The difference has been in the main countries of origin, shifting away from European and British to Asian, Oriental and Caribbean sectors. The impact of this change has especially affected the delivery of health care in larger cities such as Vancouver, Toronto and Montreal (Statistics Canada, 1993).

With an increased understanding of the special needs of immigrant populations, the hygienist can offer improved care to this group. People who migrated voluntarily bring a different set of experiences than those who fled their homeland for safety reasons (refugees). Some researchers have found that regardless of their place of origin and diversity of culture, most immigrants have a number of issues in common that affect their experiences of health and illness (Anderson, Waxler-Morrison, and Richardson, 1990). For the purpose of this paper, the term immigrant will refer to fairly recent arrivals to our country who are from cultures that are significantly different from North American.



DOROTHY CAIRNS, RDH

It is important to avoid stereotyping members of ethnic groups. While there may be some shared beliefs, values and experiences amongst a given ethnic group, there may also be a wide diversity within that group. Members may be from different classes, districts or religious sects and have adapted to North American culture by varying degrees. Some researchers found that each group within an ethnic community tends to see itself as unique from the others (Williams, Ahmed, & Hussain, 1991). Hygienists must be cognizant of cultural diversities as well as each individual's uniqueness when delivering culturally sensitive care. Statements in this paper made about particular ethnic minorities are not meant to stereotype that group, but are included to enlighten the reader to a variety of perceptions.

Cultural Beliefs/Values

Individuals' approaches to health care are influenced by the system in their homeland, religious beliefs and previous experiences. For example, North Americans believe that people are capable of controlling and solving problems. Other cultures may be more fatalistic, accepting such things as disease and suffering more easily or treating them in a spiritualistic manner. While a dental hygienist may feel that obtaining bright, white teeth is desirable, darkened teeth may be perfectly acceptable to someone from another culture.

North American culture perceives time in terms of clock time, and uses it to control the environment. In contrast, other cultures may perceive time in terms of the right time to do something and believe that people must integrate with and adapt to the environment rather than change it. In some countries, for example, the pace is slow and people often arrive late for scheduled events (Anderson et al., 1990). Medical care is dealt with strictly on a first-come-first-served basis, therefore the concept of making appointments and arriving on time may be new.

In some cases immigrants may find such a great difference between Western and traditional approaches to medicine they use a combination of the two. They may seek Western medicine for acute illnesses, but use traditional medicines to treat conditions with more prolonged symptoms, trying the alternate approach if one doesn't work. If patients feel that the Western medicine prescribed is too strong, they may modify the dosage or supplement it with herbal remedies. Stephenson, (1992) found that the Vietnamese in his study commonly reduced the amounts and shortened the duration of prescription drugs because they

felt the drugs were too powerful and were more appropriate for larger people.

The extended family unit may play an important role in health-care decisions. The views of elders are respected and may influence a person's choice to use traditional or Western medicine. A patient who has agreed to a certain treatment may not follow it if the family does not approve (Anderson et al., 1990).

Some practices of other cultures may be misinterpreted by health officials. For example, Cambodians use a traditional practice known as coin rubbing to treat headaches, colds, fever, stomach-aches, dizziness and fatigue. It involves rubbing an area with a metal spoon or coin until it becomes red and causes a bruising that can be mistaken for evidence of child abuse. Anderson et al., (1990), states that "Health professionals should be cautious of their interpretation of what constitutes abuse and should take time to assess the situation carefully."

Some immigrants may expect the practitioner to know what is wrong and be able to prescribe treatment without needing the intimate details asked for in a "nosy" medical-dental history (Anderson et al., 1990). According to Stephenson, (1992), the El Salvadorans that he studied felt that physicians asked too many probing questions. He speculated that these patients had reason to fear authority figures because of previous mistrust, caution and suffering in their homeland caused by people in power.

In some studies, immigrants indicated that they would prefer same-gender professionals when seeking care. Stephenson, (1992) noted that Vietnamese women who experienced sexual abuse en route to Canada have considerable trouble with physical examinations and prefer female care-givers. Williams et al., (1989) found that some mothers would prefer that they and their daughters are treated by a female dentist.

Traditional Oral Hygiene Practices and Service Use

Oral hygiene practices vary depending on religious beliefs, traditions brought from the homeland, and the degree of "Westernization". One author has found that first-generation immigrants in particular tend to keep practices characteristic of their country of origin (Williams & Fairpo, 1988).

Some research has suggested that some traditional methods, such as the Asian chewing stick and tongue scraper, are just as effective for plaque removal as the toothbrush, although they lack the additional benefit of fluoride toothpaste (Williams, Ahmed & Hussain, 1991). Other products used for mouth care may contain potentially harmful substances such as sugar, lime, salt or tobacco as their ingredients.

In India, tobacco is smoked, chewed and even applied in the form of tooth-cleaning powders. A mixture called "pan" is chewed or sucked and often left in the mouth overnight. It leaves stains around the teeth and dramatically increases the risk of oral cancer. Williams et al., (1991) note that oral malignancy accounts for more than one third of the deaths due to cancer in India, and about 90% are caused by chewing and smoking habits.



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In some instances, personal dental hygiene is generally good and the teeth are cleaned daily, but poor nutrition experienced in substandard living conditions, such as refugee camps, has contributed to disease of the gums and teeth (Anderson et al., 1990). Dental hygienists must look at the total context of their patients' lives to determine what may have contributed to their oral conditions.

Anderson et al., (1990) notes that the dental status of immigrants is often poor (except for the small minority of wealthy immigrants). Poverty, the absence of public health education and preventive dentistry, and the shortage of affordable dental care in their homeland may make cavities, missing teeth and periodontal disease common. Often it is the practice to extract a painful tooth rather than have it restored.

Studies have noted that even though some ethnic minorities may have higher levels of caries than the indigenous population in the same area, they are less likely to use dental services, even if they consult physicians regularly (Williams & Gelbier, 1989 and Williams et al., 1991). The Canadian health care system is so different from their previous system and so wrought with red-tape that many immigrants find it intimidating and confusing (Anderson et al., 1990 and Stephenson, 1992). For example, the practice of seeing a dentist on a long-term preventive basis instead of for emergencies may be new to them.

Psycho-Social Determinants

Depression can be a major problem for new immigrants. They may face unemployment, poverty, loss of social status and culture shock (Williams et al., 1991). Some researchers found that family tensions may rise as children begin to accept the ways of their new home while their parents stick to old traditions (Anderson et al., 1990). Some refugees are victims of torture and worry about family, friends and possessions left in a homeland still ravaged by war (Stephenson, 1992 and Anderson et al., 1990). They may be suspicious and fearful of expressing their problems to dental staff whom they equate with authority figures of their previous country where dental clinics were run by the government.

It is generally agreed that language is the most frequently identified barrier to seeking and receiving adequate health care. It may be difficult for patients to accurately express needs, for the clinician to obtain an accurate health history or for information regarding treatment to be explained and understood. This may be especially true for women and elderly parents who have had less opportunity to learn the new language (Anderson et al., 1990).

Reliance on family members, the most common solution to translation problems, is not always effective. Stephenson, (1992) suggests that this causes status reversals in families where children translate for their parents, and makes privacy within a family impossible. Patients may withhold crucial information, omitting personal history or minimizing symptoms to avoid upsetting their families.

Untrained volunteers are occasionally used as translators. However, with little or no medical training, these translators are often overwhelmed by culturally different approaches to health care, western terminology, medical terms and pharmaceutical jargon. They may bias or distort the information by judging what is important to report based on their own values and opinions.

North American culture tends to have a direct, informal style of communicating which minimizes differences in status to make others feel more comfortable. In some cultures, differences in status and hierarchical rank are noted and stressed, while communication follows a predictable formal series of steps. For example, respect for age may be important and addressing elders by their first name considered disrespectful. Conflicts may be avoided or replied to in an indirect way (Anderson et al., 1990).

Some immigrant patients may believe that it is impolite and disrespectful to ask questions. Their polite smiling and nodding (indicating attentiveness) may be falsely interpreted as agreement by the practitioner (Anderson et al., 1990). Other nonverbal gestures may have different meanings to different cultures. For example, North Americans

"the lack of cultural understanding increased the tendency for health professionals in the study to impose their beliefs and values upon patients"

generally interpret direct eye contact as being open and honest, while in other cultures it is considered disrespectful and rude. Immigrants attempting to show respect and humility by avoiding eye contact may be misinterpreted as "trying to hide something" (Anderson et al., 1990).

Economic factors may play a major role in the way immigrants access dental care. Unemployment or under-employment are common problems. Lack of English language skills and Canadian qualifications means that even trained professionals may have to take whatever menial jobs they can find. These low-paying jobs do not have the benefits other Canadians take for granted, such as time off work to visit the dentist and dental plans to help pay for treatment. Although people may be receptive to preventive care, treatment may be postponed if money is needed for more important priorities (Anderson et al., 1990).

Anderson et al., (1990) states, "while physicians are highly respected in Third World countries, nurses do not always have the same prestige." There are few schools, and most nurses are trained on the job. Some immigrants may not understand the educational background, role or scope of practice of the dental hygienist and may wonder if they are receiving adequate care when not being treated by the dentist.

It may be that people who have had limited access to medical care, have traditionally used home remedies, and who believe in spiritual treatment for illness have little understanding of the North American health care system (Anderson et al., 1990). They may treat toothaches at home and be unaware that there are specialized doctors to take care of them. To find the right doctor, communicate their needs, and follow the correct procedures is a problem for immigrants with minimal understanding of the health practices and the language used to describe them.

INTERESTED IN PRACTISING IN B.C.?

Employment opportunities for dental hygienists still exist in some regions of the province of British Columbia.

Dental Hygienists may qualify for Registration and Licensure and be exempt from the Board Examination if they are:

- 1) graduates of a dental hygiene program accredited by either the Canadian Dental Association or the American Dental Association;
- 2) not considered to be an unsuccessful candidate in their most recent Board Examination attempt in any province or state;
- 3) able to provide a letter of good standing from the licensing jurisdiction in which they are currently, last licensed or graduates within the current year; and,
- 4) able to provide proof of practising dental hygiene for a minimum of 120 days within the 3 years preceding the date of application.

Competency in the administration of local anaesthesia is mandatory for licensure in British Columbia. Conditional registration may be granted to allow time for completion of a local anaesthesia course that is approved by the College of Dental Surgeons.

For more information, or to obtain application packages, please contact:

**The Registrar's Office, College of Dental Surgeons of B.C.
500-1765 West 8th Avenue, Vancouver, BC V6J 5C6
(604) 736-3621 or fax (604) 734-9448**

Professional Beliefs/Views

Many researchers agreed that caregivers create barriers if they stereotype members of ethnic groups rather than recognize them as unique individuals (Anderson et al., 1990). Lyons (1989), believes that the poor, including immigrants, are discriminated against by dentists who have preconceived ideas of their reliability. He says that many dentists justify their decision to not take poor patients by complaining that they don't have transportation or education, don't keep appointments, and don't have the same values.

Stephenson (1992) noticed a resistance to providing culturally sensitive care amongst some health care workers. He found the attitude that immigrants "should adopt our ways, and that we should not try to adapt to theirs." Morey and Leung (1993) believe that the effectiveness of health care is often undermined when health policies and practices are based on values and beliefs that differ from those of the patients. They

recommend that health care be planned and presented in a manner that is compatible with cultural values and beliefs.

A recent study on the multicultural knowledge of a non-random sample of dental hygienists in the states of Wisconsin and Upper Michigan found that respondents possessed a low level of knowledge of beliefs, lifestyles, and health practices of ethnic minority groups. Age, education and the amount of professional experience had no effect on the dental hygienist's knowledge level. However, the lack of cultural understanding increased the tendency for health professionals in the study to impose their beliefs and values upon patients (Morey and Leung, 1993).

Implications for Practice and Research

Much of the literature stressed the need to develop a dental hygiene curriculum to help students "clarify values, prejudicial attitudes, and misconceptions about individuals from ethnic minority groups as well as to learn about the values beliefs, lifestyles, health practices, and biological variations of these groups" (Morey et al, 1993). Williams et al., (1989) recommends that information on cross-cultural communication be available to dental hygiene students and practising hygienists.

Aday and Forthofer, (1992) recommend the establishment of resident training opportunities for dental and dental hygiene students in low-income minority areas. They believe that groups with no dental coverage could benefit from the availability of subsidized resident training or public health clinics in their neighbourhoods. Lyons, (1989) and Morey et al., (1993) encourage the recruitment of students

and faculty members from ethnic minority groups so that immigrants can be cared for by people of their own culture and the dental hygiene profession can build a larger transcultural knowledge base.

Anderson et al. (1990) believe that before practitioners can begin to help immigrant patients, they must determine how their own personal values affect interactions with the patients. They warn that differences in viewpoints can lead to misunderstandings and affect the results of treatment. It is important that patients are not rejected for non-compliance and that the hygienist remains positive regardless of what choices are made.

In order to find out as much as possible about each individual's "story," dental hygienists must become skilled at inoffensive and carefully timed questioning. They must find innovative ways to communicate with their patients, to incorporate nontraditional beliefs into patient assessments and treatment plans, and ensure patient compliance through careful followup.

Stephenson, (1992) recommends the hiring of a community health advocate to assist immigrants in accessing health care. Dental hygienists could take a more active role in supporting such proposals as well as advocating for universal dental insurance, school-based preventive programs, and targeted outreach programs.

Stephenson also recommended the development of translated teaching videos and written materials for new Canadians. He suggests a simple translated voice-over dub of videos already in existence. Dental hygienists could oversee the translation of present dental videos and resources as well as the creation of new ones. These materials could be used to help immigrants access dental information, learn oral hygiene procedures and clarify differing health perceptions. As well, local health units or dental professional associations may have existing translated dental health materials available for distribution.

Discussion

There is a shortage of dental literature on this subject, especially from Canadian sources. Few sources were found in dental hygiene publications. The other health professions are far ahead of us, both in research and action. The multi-disciplinary projects reviewed had only minimal dental input and little dental emphasis.

More research is needed on the factors that prevent immigrant minorities from seeking dental care and the changes needed to improve access for them. Canada needs a statistical database for planning in order to prevent unmet needs and misdirected programs in the future. More comprehensive surveys of the attitudes of dental hygienists toward ethnic groups and the care of those groups would also be beneficial when designing education programs.

Dental hygienists have the skills to find solutions to many of the problems presented. They can start by finding out more about the immigrant groups in their areas and by avoiding the stereotyping of members of those groups. This paper only briefly touched on some of the many unique characteristics of diverse cultures in Canada.

In order to be effective partners in care, dental hygienists must closely examine the manner in which they relate to immigrants in their community, their workplace and their country. Do they regard immigrants as "problem patients" or patients with unique needs? Do they respect and accept differing values, even when they conflict with their own? Do

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they provide additional support and encouragement when antibiotics or preventive practices are indicated?

Dental hygienists who understand the diverse expectations and viewpoints of immigrant patients will be better able to accommodate their needs and increase compliance to preventive recommendations. They can share this knowledge with colleagues, participate in multidisciplinary/multicultural projects, and become advocates for culturally sensitive dental care. Dental hygienists could be the leaders in this relatively new initiative in dentistry.

Conclusion

This paper discussed some of the cultural and professional beliefs, values and practices as well as psycho-social determinants that can affect how dental health services are delivered to immigrant minorities. Some of the difficulties mentioned can be reduced or overcome if dental hygienists adapt to immigrants by respecting differences, and providing simple and patient teaching for those who need it. For dental hygienists, this means educating themselves to the special needs of immigrants, examining their interactions with them, and sharing the knowledge they gain with others in the profession. It also means becoming more active on multidisciplinary teams and as advocates for minority issues. Dental hygienists must take a strong role in the promotion of oral health awareness and in conducting research projects. As Williams et al., (1989) said, "We need to provide an equally good service to all patients, whatever their colour, race or creed."

Bibliography

Aday, L., & Forthofer, R. (1992). A profile of black and hispanic subgroups' access to dental care: findings from the national health interview survey. *Journal of Public Health Dentistry*, 52, (4).

Anderson, J., Richardson, E., & Waxler-Morrison, N. (Eds.). (1990). *Cross-Cultural Caring: A Handbook for Health Professionals in Western Canada*. Vancouver, B.C.: University of British Columbia Press.

Lee, J., & Kiyak, H. (1992). Oral disease beliefs, behaviors, and health status of Korean Americans. *Journal of Public Health Dentistry*, 52, (3).

Lyons, S. (1989). Learning the language of public health. *Access*, 3(12), pp. 7-11 (Available from American Dental Hygienist Association, 444 Michigan Ave., Chicago, Ills. 60611)

Morey, D., & Leung, J. (1993). The multicultural knowledge of registered dental hygienists: a pilot study. *Journal of Dental Hygiene*, 67, (4).

Mujumdar, B. & Carpio, B. (1988). Concept of health as viewed by selected ethnic Canadian populations. *Canadian Journal of Public Health*, (79), 430-434.

Stats Canada. **Ethnic Origin**. Ottawa: Industry, Science and Technology Canada, 1993. 1991 Census of Canada. Catalogue number 93-315.

Stephenson, P. (1992, April). **The Victoria multi-cultural health care research project**. Paper presented at the annual meetings of the Canadian Council on Multi-cultural Health Care, Whistler, B.C.

Weller, B. (1991). Nursing in a multicultural world. *Nursing Standard*, 5, (30), 31-2.

Williams, S. & Fairpo, C. (1988). Cultural variations in oral hygiene practices among infants resident in an inner city area. *Community Dental Health*, 5, (3).

Williams, S. & Gelbier, S. (1989). Dentists and ethnic minority communities. *British Dental Journal*, 166, (6).

Williams, S., Ahmed, I., & Hussain, P. (1991). Ethnicity, health and dental care-perspectives among British Asians:1. *Dental Update*, 18, (4).

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Dental hygienists that represent ethnic minority groups or work closely with ethnic minority groups are encouraged to share with the profession, information regarding their experiences and the implications of the inherent cultural beliefs on oral health.

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Radiographic Imaging for Dental Auxiliaries (Second Edition)

Dale A. Miles, Margot L. Van Dis, Catherine W. Jensen, Ann Bruno Ferretti
1993, W.B. Saunders Company
307 pages

Reviewed by: Brenda Udahl, SDT, RDH,
Dental Hygiene Faculty, SIAST, Regina, SK

What comes first, the chicken or the egg? What comes first, principles of radiation physics, or radiography technique? This is a textbook written to serve all the needs of dental assisting and hygiene students in regards to radiographic imaging...with one difference — the sequencing of the chapters. Intraoral technique and film processing are at the beginning, while radiation biology and protection do not appear until the last chapter. The authors felt that this would more closely approximate the sequence of instruction in dental radiology programs.

The authors discuss the principles of radiation technique, physics, interpretation and biology. In keeping with current trends, they also include very short sections on infection control and legal aspects of dental radiology. Also, the long cone, or paralleling technique is emphasized over the bisecting angle technique. A series of diagrams illustrates how even endodontic films may be taken using the paralleling method.

Study of this text is facilitated by a judicious blend of print, diagrams and white space. Each chapter concludes with study questions, and the rationale for choosing the correct answer is included in the answer key. Most of the material is suitable for self-study, but the authors may wish to add photographs of the skull to clarify interpretation of anatomy on panoramic films. The sequencing of the chapters also may be confusing, as constant references to future chapters are scattered throughout the first few sections.

I recommend that this text be used carefully. Supplementary information on infection control must be given. Radiation biology and safety must be emphasized, as this information does not appear until the last chapter. Lastly, in order to completely update their text, perhaps the authors could replace the term "auxiliaries" with one more appropriate for the '90's.

Radiographic Interpretation for the Dental Hygienist

Joel Iannucci Haring, Laura Jansen Lind
1993, W.B. Saunders Company
197 pages

Reviewed by: Brenda Udahl, SDT, RDH,
Dental Hygiene Faculty, SIAST, Regina,
Saskatchewan

What an exciting title! The use of the word "interpretation" in connection with dental hygienists suggests a text that covers not only basic anatomy, but goes one step beyond, and touches on some pathology, especially periodontal conditions. This text does not disappoint. Dental radiographs are a valuable diagnostic tool, but only when interpreted completely. Dental hygienists who develop this skill can facilitate comprehensive client care in their practice settings.

The authors have compiled a thorough reference of radiographic interpretation information that usually cannot be found in one textbook. Chapters begin with a list of objectives and key words, and end with a short quiz. Carefully-drawn diagrams accompany most radiographs. These diagrams are excellent, and increase understanding of the conditions shown.

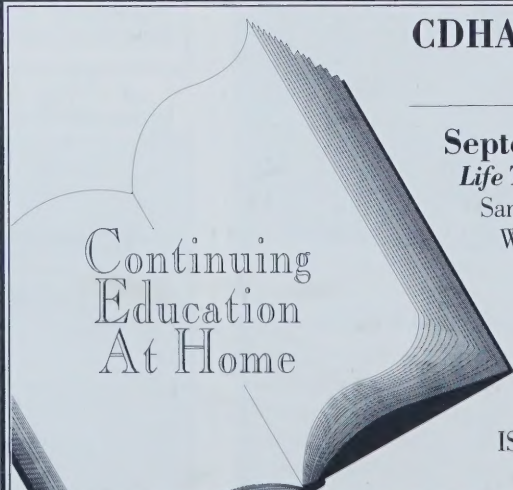
The book begins with a well-written explanation of the difference between interpretation and diagnosis, the benefits of radiographs in client education and care, and defines some of the common oral conditions that one may find on a radiograph. The

following chapters are grouped logically in sequence, beginning with basic anatomy, restorations, and caries, before proceeding with interpretation of periodontal diseases, trauma and lesions. There is also a detailed chapter on identifying normal anatomy on panoramic film.

This is an excellent reference text, for both students and practicing dental hygienists. While it does not include information on radiographic principles or biology (which was not its intent), the material presented is necessary for dental hygienists to know, so they can feel confident they are making the best use possible of dental radiographs. 

DID YOU KNOW?

According to an article appearing in the fall 1992 issue of *Prospects*, a government tabloid produced annually by Canada's Department of Employment & Immigration, the dental hygiene profession is one of this decade's 10 hottest jobs! The article states that, based on Employment and Immigration Canada predictions made in 1991, the following occupations are among the fastest growing in the country: respiratory technicians, systems analysts, occupational therapists, child care workers, technical salespersons, physiotherapists, computer/word processing operators, paralegals/law clerks, **dental hygienists** and health administration. However, the article does caution readers that an occupation that is expected to be fast growing does not necessarily mean there will be a shortage of workers in the area.



CDHA's Book of the Month Suggestions

September

Life Types

Sandra Hirsh & Jean Kummerow
Warner Books Inc., New York, 1989

October

The Seven Habits of Highly Effective People

Steven Covey
ISBN 0671708635

Dental Hygiene Care for Individuals with Special Needs

SELF-ASSESSMENT TEST

Situation:

Mr. Smith, a 30-year old computer programmer, arrives alone with his seeing-eye dog at the dental office. His appointment is for a new patient examination and oral hygiene instructions. Questions 1 and 2 refer to this situation.

- When Mr. Smith **first** arrives, the dental hygienist or the receptionist should
 - Escort the dog outside.
 - Hand Mr. Smith the health questionnaire and consent form.
 - Describe the waiting room layout and office policies to Mr. Smith.
 - Interview Mr. Smith in the waiting room regarding his health and dental history.
 - Question Mr. Smith about his blindness.
- The **most** appropriate educational strategy for providing Mr. Smith with oral hygiene instruction is:
 - Physical guidance of the toothbrush intraorally, with verbal instructions.
 - An audiotape.
 - A videotape.
 - Physical guidance and use of disclosing tablets for use at home.
 - A mouth model.

Situation:

Sean, a 23-year old, is confined to a wheelchair from a spinal cord injury at the C6 level, caused by a motorcycle accident 8 months ago. At the rehabilitation facility where he resides, he can move his shoulders and use his wrist muscles to some degree. He was formerly a high school athletic coach. Questions 3-5 refer to this situation.

- Sean's oral hygiene care will require:
 - Total dependence on another person
 - Use of adaptive equipment
 - Use of a regular toothbrush that is angled at 90 degrees
 - No adaptations
 - Use of a mouth stick
- Which of the following conditions represents a medical emergency for someone with a spinal injury?
 - Incontinence
 - Tremors
 - Heterotopic ossifications
 - Autonomic hyperreflexia
 - Muscle spasms
- During an appointment in the dental office, this patient will definitely require:
 - Transfer from a wheelchair to a dental chair
 - Diaphragmatic coughing
 - An upright chair position
 - That a rubber dam not be used
 - General anaesthesia

Situation:

Mrs. White is a 40-year old, regular dental patient. The dental hygienist notices that one corner of her mouth and one lower eyelid are drooping and that her speech is somewhat slurred. Mrs. White noted a recent viral infection on her health history. Questions 6 and 7 refer to this situation.

- Mrs. White **most** likely is suffering from:
 - Bell's palsy
 - Cerebral palsy
 - Alzheimer's disease
 - Parkinson's disease
 - None of the above
- The **most** important precaution to take during dental treatment with Mrs. White is:
 - Adequate suctioning
 - Protection of the airway and eyes
 - Antibiotic coverage
 - Special infection control procedures for the viral infection
 - Avoidance of quick movements
- Which of the following disabling conditions is **not** generally associated with cerebral palsy?
 - Seizures
 - Visual defects
 - Hyperthyroidism
 - Hearing disorders
 - Speech disorders
- The **most** optimal time to schedule a dental appointment for a patient on hemodialysis is
 - Immediately after dialysis
 - Dental treatment is contraindicated for patients on hemodialysis
 - 24 hours after dialysis
 - 4 hours after dialysis
 - Time is not a critical factor.
- All of the following groups are considered high risk for transmission of hepatitis virus, types B or NANB except:
 - Hemodialysis patients
 - Hemophiliac patients with severe factor deficiency
 - Tuberculosis patients
 - Male homosexuals
 - Indochinese refugees
- The **most** critical oral health problem for patients with Down syndrome is usually:
 - The high dental caries rate
 - Malocclusion
 - Bruxism
 - The periodontal condition
 - Oral cancer

- Premedication with antibiotics before dental treatment to prevent infectious endocarditis is recommended for patients with a history of **any** of the following conditions **except**:
 - Myocardial infarction
 - Rheumatic heart disease
 - Prosthetic heart valves
 - Ventriculoatrial shunt for hydrocephalus
 - Pathologic heart murmur
- Problems associated with cleft palate that can affect dental health or the receipt of oral health care include **all** of the following **except**:
 - Blood dyscrasias
 - Speech difficulties
 - Hearing loss
 - Feeding problems
 - Nasal problems
- An 8-year old boy runs into the office with his mother and proceeds to touch everything in sight. When you talk to him, he is constantly in motion and cannot concentrate on your questions. When you seat him in the dental chair and push the recline button, he exhibits a severe startle reflex. He cannot follow directions well and appears uncoordinated when brushing his teeth. This boy **most** probably is diagnosed as:
 - Emotionally disturbed
 - Learning disabled/minimal brain dysfunction
 - Cerebral palsied
 - Epileptic
 - Leukemic
- Routine dental treatment is contraindicated in **all** of the following conditions **except**:
 - Acute or recent myocardial infarction
 - Mild arrhythmias
 - Unstable angina
 - Congestive heart failure
 - Open heart surgery (within the past 3 months)
- Xerostomia is a common oral manifestation accompanying **all** of the following conditions **except**:
 - Leukemia
 - Radiation therapy
 - Mental retardation
 - Chronic alcoholism
 - Diuretic drug therapies

Answer Key:

1. c	2. a	3. b	4. d
5. a	6. a	7. b	8. c
9. c	10. c	11. d	12. a
13. b	14. b	15. b	16. c

CDHA extends thanks to Mosby - Year Book, Inc. for granting permission to reprint these questions which are taken from the 'Review Questions' to Chapter 14 (pp. 570-573) of the text *Mosby's Comprehensive Review of Dental Hygiene*, Second Edition, edited by Michele Darby and Eleanor Bushee, 1991, Mosby - Year Book, Inc., St. Louis, Missouri.

October 1993

		<i>SPONSOR</i>	<i>LOCATION</i>	<i>FOR INFO CALL</i>
2	Enhancing Success in Oral Hygiene Instruction & Periodontal Maintenance with the High Risk Patient: Combined Behavioral & Pharmacological Strategies – Dr. Philip Weinstein	Interior Dental Hygienists' Society	Kelowna, B.C.	(604) 763-6811 (day) (604) 762-6898 (eve.)
2	New Perspectives in Treating Older Patients – Dr. P. Lloyd	Dalhousie University	Halifax, NS	(902) 494-1674
15-17	CDHA's Professional Conference — An Exploration into the Future: A North American Research Conference	Canadian Dental Hygienists Association	Niagara Falls, ON	(613) 728-8730
16	Current Developments in Restorative Materials and Techniques – Dr. K. Leinfelder	University of Alberta	Calgary, AB	(403) 492-5023
22, 23	Basic & Advanced Periodontics for the 90's – Dr. Murray Arlin	Dr. M. Arlin	Richmond Hill, ON	(416) 243-5215
Oct. 22- Nov. 12	CPR – Basic Rescuer & Recertification	Faculty of Dentistry University of Toronto	Toronto, ON	(416) 979-4503
23	Early Orthodontic Treatment: The Good, The Bad, & The Ugly – Dr. David Kennedy	Dalhousie University	Halifax, NS	(902) 494-1674
23-24	Preventive Dentistry Forum	University of Toronto	Toronto, ON	(416) 979-4503
30	Photography in Dentistry	Faculty of Dentistry University of Toronto	Toronto, ON	(416) 979-4503
30	Basic Rescuer CPR and Airway Management – Canadian First Aid School	University of Alberta	Edmonton, AB	(403) 492-5023

November 1993

6	X-Ray X-Cellence – Dr. B. Pass, Dr. T. Blackmore	Dalhousie University	Halifax, NS	(902) 494-1674
6	Current Concepts in Non-Surgical Periodontal Therapy – Prof. Denise Bowen	University of Manitoba	Winnipeg, MB	(204) 789-3331
12-13	Strengthening Dental Hygiene in Today's Practice – Dr. J. MacDonald, Ms. K. Hilborn, Ms. P. James	University of Alberta	Calgary, AB	(403) 492-5023
18-21	Canadian Bioethics Society's 5th Annual Conference	Canadian Bioethics Society	Montreal, PQ	(514) 343-2142
26-27	Clinical Photography: A Hands-On Approach – Dr. P. Major, Mr. D. Marston	University of Alberta	Edmonton, AB	(403) 492-5023

As CDHA's Continuing Education Coordinator, I would like to extend a special thank you to Linda Talbot of British Columbia who has been working to compile a list of upcoming continuing education opportunities for our members from various program sponsors. It is no small task to access information with enough advance notification to meet publication deadlines. Thank you Linda for your dedicated efforts.

I would also like to welcome Janice Edgar, who was recently appointed as CDHA's Director of Communications at Central Office and will be helping to coordinate the list of course offerings for each issue of PROBE. If you are aware of any relevant continuing education opportunities in your province, please forward the information to CDHA's Central Office or call Janice at 1-800-267-5235.

Nancy Keselyak
CDHA Continuing Education Coordinator

Preventive Dentistry Forum

presented by the University of Toronto's Faculty of Dentistry

October 23, 24, 1993

9:00 am – 5:00 pm

Tuition: \$250.00 D.D.S. **Location:** Faculty of Dentistry,
\$150.00 DH. 124 Edward St., Toronto

"Home care Products and Office Procedures for the Preventive-oriented Dental Practice" – a 2-day Forum in Preventive Dentistry

This course is directed to prevention-oriented general practitioners, dental hygienists and dental assistants. The 2-day forum is presented under the general direction of Dr. Hardy Limeback. Lectures will include scientific assessments of recent developments in oral care home products, topical fluorides and tooth whiteners. Presentations will be more practical than theoretical. Presenters will review current standards of practice in Preventive Dentistry and provide useful tips and hints on how to effectively use and manage the new developments in Preventive Dentistry in the best interest of the patients.



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VITALITY

PARTICIPATION



The Canadian Dental Hygienists Association presents... An Exploration into the Future A North American Research Conference Preliminary Schedule of Events • October 15-17, 1993 • Niagara Falls, Ontario

It's just around the corner... if you haven't registered yet call 1-800-267-5235 to find out how you can!
Here's what will be waiting for you in Niagara Falls this fall:

Friday, October 15, 1993

- All Day** Moving The Profession Of Dental Hygiene Towards The Year 2000
Co-Facilitators: Wendy Halowski, Dianne Gallagher
- Evening** "Women in Science & Research"
Guest Speaker: Dr Roberta Bondar followed by Wine & Cheese Reception

Saturday, October 16, 1993

- 8:30 - 9:30 "Health Care Trends"
Keynote Speaker: Dr Jane Fulton
- 9:00 - 12:00 Commercial Exhibits
- 9:30 - 11:30 Table Clinics & Poster Sessions
- 9:30 - 12:30 Mini Sessions: Research Applications in Dental Hygiene
Moderator: Margaret Walsh, RDH, EdD
- 1) "Remaining Current in Dental Hygiene Practice"
Sharon Gravois, RDH (USA)
 - 2) "Using Research in Dental Hygiene Practice"
Linda Kraemer, RDH, PhD (USA)
 - 3) Manuscript Preparation
Marilyn Goulding, RDH, BSc (Probe-CAN)
JoAnn Gurenlian, RDH, PhD (Dental Hygiene-USA)

- 4) "Understanding the Scientific Literature"
Nancy Keselyak, RDH, MA (CAN)

— or —

- 9:30 - 12:30 Theory Development Workshop
Jacqueline Fawcett, PhD (USA)
- 2:00 - 5:00 Testing & Validating Theory Workshop
Margaret Walsh, RDH, EdD (USA); Michele Darby, RDH, MS (USA)
- 1:30 - 5:30 Free Papers
- 2:00 - 5:00 Commercial Exhibits

Sunday, October 17, 1993

- 8:00 - 9:00 Chlorzoin Therapy
A treatment researched and developed by Jim Sandham, DDS, PhD, of the University of Toronto
- 8:30 - 10:15 "Qualitative Research — A User Friendly Guide"
Karen Grant, PhD (CAN)
- 9:00 - 12:00 Mini Sessions: Research That Will Affect Future Dental Hygiene Practice
Moderator: Janice Pimlott, RDH, MSc
- 1) Lasers — Patricia Ling, DMD, MSc
 - 2) Saliva Research — Colin Dawes, BDS, PhD
 - 3) Computers in Practice — David Singer, DMD, PhD

- 4) Micro-Diagnosis — Marilyn Goulding, RDH, BSc
- 5) Health Policy, Demographics, and Economics — Joanne Clovis, RDH, MSc

- 9:00 - 12:00 "Survey Research Workshop"
Megan Kromer, PhD (USA)
- 10:15 - 12:00 "Common Flaws in Research"
Denise Bowen, RDH, MS (USA)
- 1:00 - 3:00 Corporate Panel Discussion
Moderator: Kathleen Newell, RDH, PhD (USA)
- Corporate Dental Hygiene Representatives*
Teledyne Waterpik Inc. (Marsha Stein, RDH (CAN))
Procter & Gamble (Janet Cain-Hamlin, RDH, MS (USA))
- Representatives from Government/Non-Profit Agencies*
Canadian Fund for Dental Education
Health & Welfare Canada
National Institute of Dental Research
- Dental Hygiene Researchers*
Patricia Johnson, RDH, PhD (CAN)
Karen Gross, RDH, MS (USA)
- 3:00 - 5:00 Plenary: Theory Development Workshops
Moderators: Denise Bowen, RDH, MS (USA)
Laura MacDonald, RDH, MEd (CAN)
- 3:00 - 4:30 Free Papers

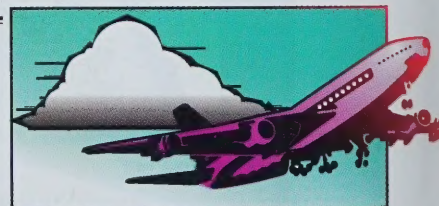
The following companies will have a Commercial Table Display which will be open to all conference participants from 8:00 - 6:00 on Saturday, October 16th. CDHA wishes to extend its sincere thanks to all participating companies for their continued support and assistance.

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Bausch & Lomb Canada Inc.
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Colgate Oral Pharmaceuticals
Dentsply Canada Ltd.
Germiphene Corporation
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Knowell Therapeutic Technologies Inc.

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Maxill Inc.
New Image Industries
Nobelpharma Canada Inc.
Oral-B Laboratories Inc.
Premier Dental Canada
Procter & Gamble Inc.
Schein, Henry Inc.
SmithKline Beecham
Teledyne Water Pik
Vivacare — Ivoclar Vivadent

How Do I Get There?

Once you arrive at either Toronto's Pearson International Airport or Buffalo's International Airport you hop on board the 'Niagara Airbus' for prompt courteous service to the Sheraton Fallsview Hotel, site of the 1993 North American Research Conference. Call Niagara Airbus directly at (416) 374-8111 for more information on airbus departure times, schedules and fares or MKI Travel and Conference Management, the official Travel Agency appointed by CDHA to coordinate travel arrangements for this event. At CDHA's request, MKI has agreed to arrange a specific shuttle service schedule for North American Research Conference participants. Call 1-800-267-9676 (US residents may call (613) 234-1395 collect) to find out how you can cut your shuttle costs by accessing a shuttle specifically reserved for CDHA conference delegates.



October is YOUR month...

National Dental Hygiene Campaign 1993

October 17-23, 1993

Dental Hygienists from Coast to Coast Getting Involved In Community Awareness During the National Dental Hygiene Campaign...



(l-r) Leanne Shirley, Joan Tomczak, Holly Wilson and Brenda Mitchelmore participating in BC Systems Corporation's "Wellness Fair", October 22, 1992 in Victoria, BC



Sharyn Milroy, one of CDHA's Health Promotion Council Members and a resident of Moncton, New Brunswick promoting the profession in a local mall.

There are only a few weeks left for you to plan your activities to support this year's National Dental Hygiene Campaign. All members received samples of the promotional materials available this year, through the Canadian Dental Hygienists Association, with the July/August issue of *Probe*. We certainly hope you took advantage of the 'sneak preview' and placed your orders early!

The National Dental Hygiene Campaign is YOUR campaign — it is a time for you to "strut your stuff" and tell Canadians about *your* profession...so, don't be shy, join your colleagues from coast to coast in an effort to raise public awareness of the dental hygiene profession and its value to Canadians.

Provincial Campaign Co-ordinators

Newfoundland

Lisa Smith
19 Sterling Cres.
St. John's, NF A1A 4G3
H(709) 753-9756 W(709) 579-6232

Prince Edward Island

Julie Muise
524 St. Peter's Rd.
RR #3, Charlottetown, PE C1A 7J7
H(902) 628-1931

Nova Scotia

Francine Pellerin
70 Lansdowne #102, Halifax, NS B3M 3Z3
H(902) 445-4627 W(902) 423-9337

New Brunswick

Jill Rogers-Cando
Comp. 39, Ste 26, SS2, Fredericton, NB E3B 5W6
H(506) 458-2780

Quebec

Dianne Farrell
465 Galland Blvd. #3E, Dorval, PQ H9S 3W7
H(514) 631-1915

Ontario

Julie Pearson
1042 Murphy Rd., Sarnia, ON N7S 2Y2
H(519) 542-1714

Manitoba

Pamela Swanson
221 Perth Ave., Winnipeg, MB R2V 0T3
H(204) 339-7856 W(204) 786-6068

Saskatchewan

Susan Vogt
3038 Zaran Cres., Regina, SK S4V 1Y4
H(306) 789-2858 W(306) 522-3634

Alberta

Sandra Cobban
20 Des Lauriers Cres., St. Albert, AB T8N 5Y6
H(403) 458-3325

British Columbia

Karen Gallagher
16275 87th Ave, Surrey, BC V3S 7S3
H(604) 572-9110

Canadian Forces

Denis Cote
BFC Valcartier, Courcellette, PQ G0A 1R0

National Campaign Co-ordinator

Dawn Mueller
131 Douglas Shore Close SE, Calgary, AB T2Z 2K8
(403) 720-0353

BC's 1993 NDHW Campaign Coordinator Urges You to Get Involved...

October 17-23, 1993 is our time to celebrate NDHW! Get your thinking caps on, brainstorm with your colleagues and put together some exciting ideas which will help to promote and celebrate our profession! The target group this year is Elementary School Children and information on how you may present a dental hygiene topic to this age-group may be available through your local health unit.

Other avenues to celebrate NDHW may be through the media, a childrens' display at your local shopping centre or a dental hygiene presentation at an elementary school. Let's take action and get involved!! If your activities are already underway — congratulations, if you are seeking advice, ideas and/or guidelines call your NDHW provincial coordinator.

This year's National Dental Hygiene Campaign sponsor is Procter and Gamble. They have offered a generous supply of promotional/educational kits to a number of public health units across the country. If you are interested in obtaining a supply of these kits, for a fee, you may want to contact Rhonda at Procter and Gamble directly by calling **1-800-668-0165**.

Enjoy NDHW and good luck on all your projects. Feel free to contact your provincial coordinator for any assistance, we'd love to hear from you.

Karen Gallagher
NDHW Provincial Coordinator,
British Columbia
(604) 572-9110

Seniors

Packages

- I "Oral Health in the Elderly: A Workshop Curriculum and Teacher's Guide" (2 available)
- II "Oral Health Education for the Elderly...A New Preventive Dental Care Program" (1 available)
- III "Training and Motivational Materials in Geriatric Dentistry" (1 available)

Manuals

- IV "Geriatric Oral Health: A Training Manual for Long Term Care Facilities" (2 available)
- V "Assessing the Aging Mouth" (1 available)

Slide-Script Set

- VI "Senior Smiles" (2 available)

Videotapes

- VII "12-Minute Videotape (VHS) for the Elderly" (In French only — 2 available)
- VIII "Options: Dental Health in Later Years" (2 available)
- IX "The Senior Smile" (2 available)
- X "Oral Health and the Elderly" (1 VHS available)

Special Needs

Slide-Script Set

- I "Prevention and Treatment Considerations for the Dental Patient with Special Needs"

Children

Videotapes

- I "Toothbrushing with Charlie Brown" (2 available)
- II "It's Dental Flossophy, Charlie Brown" (2 available)
- III "The Barnyard Snacker" (2 available)
- IV "The Haunted Mouth" (2 available)

Other

Videotapes

- I "Fluoride — The Magnificent Mineral" (2 available)
- II "Fantastic Fluoride" (2 available)
- III "Oral Problems of Patients with AIDS and HIV" (1 set available in English/ 1 set available in French)
 - Part I a) Dr. Norbert Gillmore
b) Mr. Rick Hatt
 - Part II "The Global Occurrence of AIDS"
 - Part III "HIV Associated Periodontal Disease"
- IV "Prescription for Periodontal Health" (2 available)
- V "More Than Just a Pretty Smile" (1 available)
- VI "Dentistry Update" (1 available)

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June 17-19, 1994 • Delta Bessborough Hotel • Saskatoon, Saskatchewan

Submissions of abstracts for free papers, posters, and table clinic presentations which are related to any aspect ethics and the practice of dental hygiene are invited. Your intent to submit an abstract, including your name and title of the abstract, must be made known to the CDHA Conference Co-ordinator by December 15, 1993.

The deadline for submissions of abstracts for free papers, posters and table clinics is February 15, 1994. Selection will be on the basis of the quality of abstracts. Notification to authors of accepted or rejected abstracts will be made by March 15, 1994. All selected abstracts will be published in the Conference Program. Completed papers must be submitted by April 10, 1994 for potential publication in Probe, CDHA's scientific journal.

For additional information contact: CDHA Central Office, 201-1018 Merivale Rd., Ottawa, ON, K1Z 6A5

Authors should submit one copy of Appendix A by February 15, 1994.

Appendix A for Abstract

Type perfect original of abstract here. Do not type beyond outline of box.
Include title, purpose, method & results.

CDHA's 5th Professional Conference

SHARPEN YOUR PROFESSIONAL EDGE:

"A Question of Conscience - A Matter of Choice"

**Saskatoon, Saskatchewan
June 17-19, 1994**

**Deadline date for Abstracts:
February 15, 1994.**

First Author: _____

Affiliation: _____

Address: _____

City _____ Prov./State _____

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Telephone: Bus. () _____

Res. () _____

Additional Authors (Names Only)

It is expected that first authors will present the papers unless otherwise specified.

Choice of Presentation Format

_____ Oral presentation (Free Paper)

_____ Poster presentation

_____ Table clinic

Abstracts should be submitted to:

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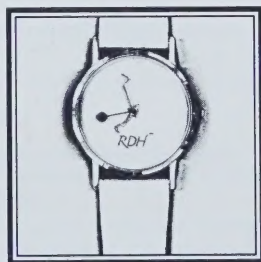
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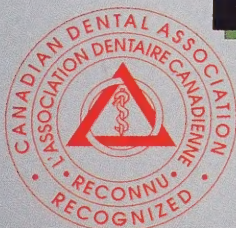
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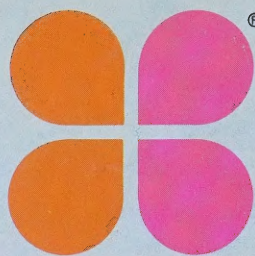
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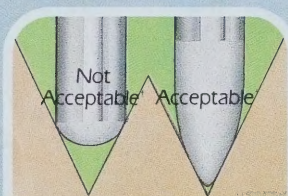
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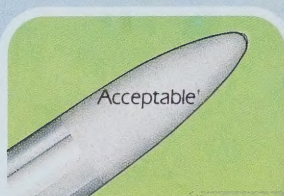
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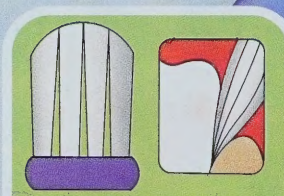
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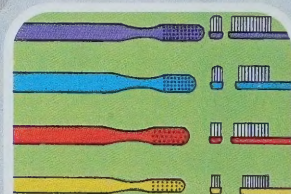
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PROBE

VOL 27, NO 6

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*Polk-Lepson Research Group



Behind the Pages of *Probe*

Another year has passed and the little elves are getting ready to put the journal down for a long winter's nap (that is until the holidays are over!). While all is quiet, I thought you might like a look behind the scenes.

Even as the Christmas snow flies, the heart of CDHA is vigorously beating in Ottawa, in our Central Office. Its pacemaker is Carol Matheson Worobey, CDHA's Executive Director for the past ten years. She and her staff receive, store and re-direct all of CDHA's communication. They co-ordinate all council activities and provide a central core to all activities. To list their full responsibilities would, no doubt, fill this journal in its entirety. They have surely performed their duties well and no doubt their stockings will be filled with our thanks on Christmas morning.

Our journal, *Probe*, has gone through considerable evolution in content, format and personnel responsible for its production. When I first came to the publication, it was put together by myself and the executive director. We then solicited the assistance of a part-time staff person to copy edit and interact with the printer's office. As the load of work became heavier we enlisted the help of a volunteer "contributing editor".

This past year has seen the biggest change in the increase of the publication, from quarterly to bimonthly. Needless to say, the workload doubled and drastic changes were required to meet these new demands. For this, and other communication needs, we welcomed to our staff our new Communications Director/Managing Editor, Janice Edgar. Janice is a graduate of Carleton University's School of Journalism (1984) and her past work experience with the Government of the Northwest Territories Departments of Health, Education and Social Services coupled with her four years experience as Convention Coordinator for the Canadian Dental Association make her a valuable addition to the Central Office team. She is very much a lady of deadlines and will surely keep the journal on track and in the hands of you, the reader.

The volunteer positions of our journal include Editorial Director, Scientific Editor, Contributing Editor and Statistics Reviewer. Our Editorial Director, Dianne Landry receives all the incoming material. In addition



MARILYN GOULDING, RDH, BSC

tion she researches, reviews, edits and writes content for *Probe* and presents the package of raw material to Janice to begin the publication process. Dianne is new to the Ottawa region and comes to us from Saskatchewan. Her background as a hygienist, therapist and educator in the dental field qualifies her for this position and she is a most welcome addition to our team.

Our Contributing Editor is a valued colleague, Carol Barr Overholt. She will be compiling a new and interesting section in our journal which will identify current literature of interest to dental hygiene. You will see the material in abstract form with direction to the proper source for the full article. It will be a walk through what's happening in research. Carol has an impressive background; she graduated from the University of Pennsylvania, Dental Hygiene program in 1982 and is currently completing a B.Ed at Brock University. Coupled with clinical practice in the specialties of ortho and perio, she has been teaching for the past six years in dental and biological science programs. She is currently a full-time faculty member at Niagara College. With the addition of Carol we have a most capable team.

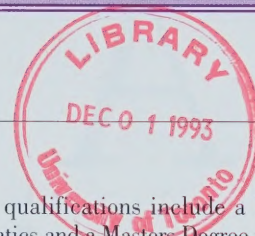
Our Statistics Reviewer is Mr. Robert Dunford. He is responsible for any papers in a study or survey format. He interprets the representation of the statistics to assure they are presented with the utmost clarity and valid-

ity. His qualifications include a B.Sc. in mathematics and a Masters Degree in statistics. He is currently the Programmer/Analyst and Chief Statistician for the Department of Oral Biology at the State University of New York at Buffalo and has been the co-investigator on a multitude of studies involving a wide range of periodontal concerns. He is very cognizant of the interests of dental hygiene and volunteers his time freely to our interests.

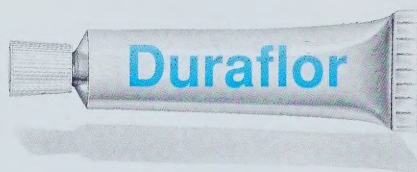
That leaves yours truly, as the Scientific Editor. You already know that I seek out and offer direction on the scientific content of the journal. I have the engaging task of receiving and reviewing manuscripts submitted by our members and other contributing authors. I'm really honored to have served the CDHA for the past four years and as I enter into my fifth, I'm happy to be a member of *Probe's* editorial team and relieved to have all this capable assistance. My background includes a Dental Hygiene Diploma from the University of Alberta in 1977 and a Bachelor of Science degree in Clinical Research and Dental Hygiene Education from Empire State College in 1988. I am currently enrolled in the Masters of Oral Science Program at the State University of New York at Buffalo, and am also a full time faculty member with Niagara College in their Dental Hygiene Program.

Last, but not least, is the Editorial Board, which acts as our official conscience. These four people represent not only the various regions of the country but also the various disciplines of dental hygiene. They offer direction and vision and an objective critique of the journal to keep us all on track and serving the needs of you, the reader.

Our profession is full of capable and giving people and we should rejoice in another year of outstanding accomplishments. As you enter this holiday season of joy and celebration don't forget to be thankful for the caretakers of your profession and give thought to joining us in the new year. We always welcome new volunteers to the team. Until then, Merry Christmas to all and to all a goodnight! Ho! Ho! Ho! 



A little tube with a lot of applications



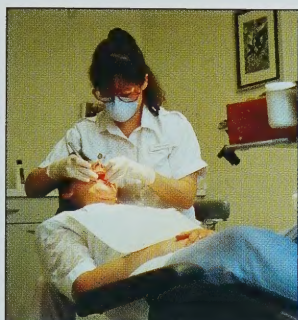
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COVER

This month our cover features colleague, **Claudine Busque**, skiing at 3000 m in Laax, Switzerland. Claudine, a native of Beaconsfield, Quebec is a 1992 graduate of John Abbott College. She worked in a clinical practice setting from the time of graduating until October 1993 in Zurich, Switzerland. She is now residing in Montreal, Quebec.



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PROBE

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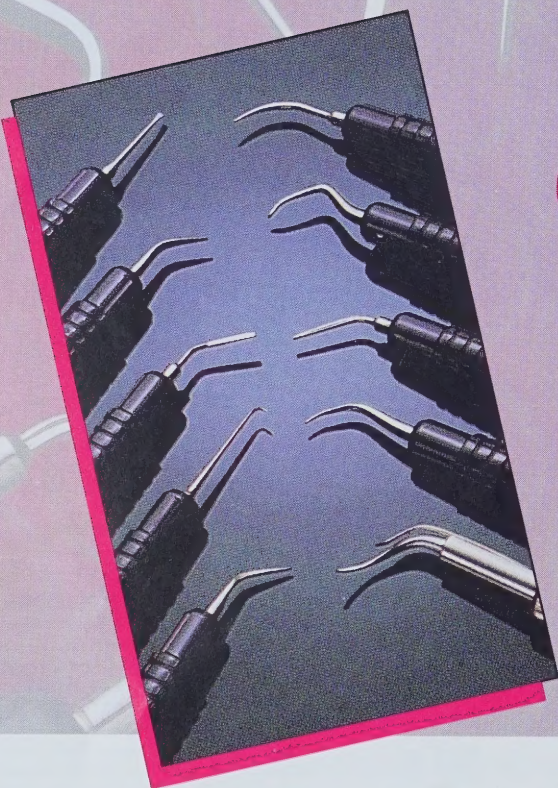
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Reflections and Resolutions

Winter is upon us and the season of cheer is about to invade our every waking moment. No matter which faith system we subscribe to, it is difficult not to greet people warmly and to think of others during the holiday frenzy. The new year that awaits around the corner poses additional challenges for starting our lives afresh. The dawning of a new year is a time for reflections and resolutions.

Dental Hygiene has an illustrious past and judging by current events our profession will have an even more diverse and challenging future. But let us not forget that our chosen profession is made up of individual people, warm bodies with hearts and souls and minds. All quite unique and all with their own personal goals and aspirations.

I am dismayed when I hear that a dental hygienist has been referred to as a "prima donna" by a member of the dental community. Unfortunately this has not been infrequent throughout my travels. A couple of years ago I wrote an article for the provincial dental bulletin entitled "The Dental Hygienist: The Dentists' Colleague". My intent was to demonstrate to our dentist colleagues that dental hygienists play an equal but different role in the practice as do the dental assistant, receptionist, technician, etc. I was surprised at some of the reactions! As per usual, most of the comments were positive or indifferent (authors learn to live with indifference!), but I did receive one scathing letter from a dentist in Victoria who obviously had no use for dental hygienists. He claimed that we were taught to be "prima donnas" and that as far as he was concerned "stewardesses" (his term) were far more valuable. At least they would know what to do in an emergency!! This dentist concluded by saying that if I wanted to be considered his colleague that I should return to dental school and then I'd still have to earn his respect! I wrote back thanking him for his opinion and for at least reading the article. What or who had made this man so angry with dental hygienists?



FRAN RICHARDSON COTTON
RDH, BScD, MEd

People who choose to study dental hygiene enter their educational program with well formed personalities. Not everyone sees or feels or reacts the same as their neighbour. In fact it would indeed be a boring world if we were all the same! Unfortunately our culture loves to put labels on everyone and everything. Yes, there are dental hygienists who have abrasive personalities but there are an equal number of dentists, nurses, teachers etc. who also have these personality traits. Most people who enter our profession are caring, independent and organized. That follows since much of what we do falls into those categories. Some are born leaders, some are born followers, and others just love to love life and work at their own pace. Sounds like any other segment of the population.

How can we foster acceptance of ourselves as professionals in our own right? We can always try to be positive in our outlook. We can support those who work on our behalf. We can celebrate our differences and accept diversity as a strength rather than a weakness. We can also accept that there will always be those among us who choose confrontation. Life won't be perfect. We CAN be

the dental hygienist who proves that we are NOT all "prima donnas". Maybe we can even drop those antiquated words from our vocabulary. To be honest, I thought we had!!

One of the goals identified by the CDHA Board of Directors is to raise the profile of dental hygienists within the community as a whole. Dental hygienists by the very nature of their personality types tend to be good participants on committees, community boards, school boards and the like. Depending on your personal time commitments and family responsibilities a resolution for the new year might entail the joining of a complementary organization. One where you can show off your talents and let the world know just who dental hygienists are!

Sometimes when you work for something so long, as we have in trying to obtain professional respect, we don't always recognize the victory when it occurs. As 1994 enters into the record book, let's be able to smile and know that there were many little victories along the way. Most of those came from our individual patients/clients if we are in private practice, our students if we are in education or our community groups if we are involved in community health. But perhaps the place to look is really within ourselves.

On behalf of the Board of Directors and Central Office, may I take this opportunity to wish you the best of the season. 

Fran is currently Chair, Division of Dental Studies, College of New Caledonia, Prince George, BC. She received her Diploma in Dental Hygiene from the University of Toronto in 1971, a BScD from the University of Toronto in 1982 and a Masters in Education from the University of Regina in 1987.

FLEX™-ABILITY

A white and blue Aquafresh Flex toothbrush is shown diagonally. The handle is blue with a white rubberized grip pattern. The neck is white and flexible, shown in a bent position. The head is white with dual bristles. The background is dark blue with a subtle wave pattern.

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New Use for Old Drug

Thalidomide, the sleeping pill that was banned 30 years ago after pregnant women who took it bore deformed babies, may have a new usage.

A new finding shows that the drug may be effective against tuberculosis and especially beneficial for victims of AIDS who contract TB.

Food and Drug Association-approved research on people — excluding women of childbearing age — is currently in progress, reports *The Bottom Line* of August 30.

Announcement

CDHA is pleased to announce that the CDHA/Procter & Gamble Graduate Student Research Award has been increased to \$5,000 beginning with the 1994-95 award. The increased value has been made possible through the generous support of Procter & Gamble, makers of Crest. CDHA gratefully acknowledges Procter & Gamble's continuous support of the dental hygiene profession and it looks forward to sharing the rewards of this partnership with its members.

1993-94 CDHA/Procter & Gamble Graduate Student Research Award Awarded to Lynda McKeown Mickelson



Lynda McKeown Mickelson of Thunder Bay, Ontario has been selected as the 1993-94 recipient of the CDHA Research Fellowship. This \$3,000 fellowship is awarded annually. Selection is made from candidates who are Canadian dental hygienists enrolled in a research-oriented Masters or Doctoral Program.

Lynda received her diploma in Dental Hygiene from the University of Toronto in 1964 and later her Honours Bachelor of Arts Degree in Philosophy and Occupational Ethics from Lakehead University, Thunder Bay.

Lynda is enrolled in the Masters Program at Lakehead University and in her studies she will be applying social theory to many aspects of dentistry and dental hygiene, an area that she feels has received very little attention in academic research.

Past recipients of this fellowship include:

1987-88	Yvonne Knazan
1988-89	Bonne Trodden
1989-90	Barbara Zier
1990-91	Ellen Brownstone
1991-92	Charla Lautar
1992-93	Charla Lautar

Call for Applicants The CDHA/Procter & Gamble Graduate Student Research Award

OBJECTIVE: To promote the research training of Canadian dental hygienists in research oriented Masters or Doctoral programs.

GENERAL DESCRIPTION: An award of \$5000.00 will be given annually to a highly qualified candidate enrolled as a graduate student in a Masters or Doctoral program.

ELIGIBILITY: Applicants for this award must be Canadian dental hygienists who are active, associate, student or life members in good standing of the CDHA who may be studying full or part time. Applicants must present evidence of having been accepted by a recognized academic institution.

APPLICATIONS: The deadline is April 1 of the year in which the award is to be given. Applications must be submitted on forms available from the CDHA Central Office.

DURATION: This award is made for one academic year for full-time students or the equivalent for part-time students. The award may be renewable for one additional academic year or its equivalent on receipt of a satisfactory progress report. The progress report must detail work to date and include any preprints or reprints arising from the work. Any request for renewal of this award should be accompanied by a letter from the research supervisor and one other referee.

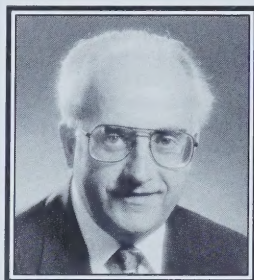
CONDITION OF SUPPORT: On completion of studies, recipients of this award agree to provide a bound copy of the thesis or project to Central Office.

For further information and application forms please contact:

**Canadian Dental Hygienists Association
1018 Merivale Road, Suite 201
Ottawa, Ontario K1Z 6A5**

New President of CDA Installed

Dr. Raymond Wenn has assumed the office of president of the Canadian Dental Association during the Association's annual meeting held in Ottawa, September 10 and 11, 1993.

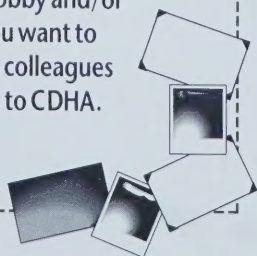


Dr. Wenn has been active in all levels of organized dentistry. He was both secretary/register and president of the Dental Association of Prince Edward Island prior to his involvement with the Canadian Dental Association, where he has served on a number of the Association's committees and councils.

Dr. Wenn is a member of the International College of Dentists, the American College of Dentists, the Academy of General Dentistry, the Pierre Fauchard Academy and the Academy of Dentistry International. He received his doctorate in dental surgery from Dalhousie University in 1975.

CDA's new President-Elect is Dr. Bryn Sigfstead of Edmonton, Alberta. The new Vice President is Dr. James Brookfield of Kirkland Lake, Ontario.

We are also interested in receiving photos that can be used on the cover of *Probe*—the theme Colleagues from Coast to Coast seems to be a popular one and will continue into the New Year—so if you or one of your colleagues have an intriguing hobby and/or pastime that you want to share with your colleagues—send a photo to CDHA.



Announcement of New Research Grant

At the North American Research Conference, the Professional Development Council proudly announced the establishment of the **Canadian Dental Hygienists Association Dental Hygiene Research Grant.**

The objective of this research grant is to support Canadian dental hygienists engaged in research which enhances the dental hygiene profession's ability to promote health and well-being.

A grant of \$5000.00 will be awarded annually to a Canadian dental hygienist involved in qualitative or quantitative research as a principal investigator or co-investigator. Preference will be given to research projects relevant to the discipline of dental hygiene and the goals of the CDHA.

Applicants for this grant must be academically qualified Canadian dental hygienists who are active or life members in good standing of the CDHA. Evidence of academic credentials at the Masters or PhD level is required.

The application deadline is March 31 of the year in which the grant is to be awarded. Applications must be submitted on forms available from the CDHA Central office.

For further information please contact:

**Canadian Dental
Hygienists Association
1018 Merivale Road, Suite 201
Ottawa, Ontario
K1Z 6A5**

NIDR Study Looks at Dental Composites

Long-term wear resistance of dental composites is the subject of a five-year study funded by the National Institute of Dental Research.

In a study of 45 patients, researchers are looking at the degree of polymerization or cure that takes place with varying amounts of exposure to blue light in the hardening process, reports researcher Jack Ferracane, PhD, of the Oregon Health Sciences University School of Dentistry.

He says the study is in its second year and that so far, things are going according to their predictions. "Increasing the amount of polymerization seems to increase the wear

resistance," he writes in *Caementum*, OHSU alumni newsletter.

"The NIH (National Institute of Health) is pushing for replacement materials for amalgam, actively requesting research into alternative materials," he notes. "Composites are the likely candidate, but there are still a couple of problems."

In addition to the wear resistance, he writes, there is the problem of shrinkage as the composites cure, affecting the seal with the tooth. "I think an esthetic material that will completely replace amalgam is still five to 10 years away," he said.

Nutrition Factsheets Available to CDHA Members Through the Canadian Dietetic Association



In August 1993, the Canadian Dietetic Association (CDA) introduced a new subscription series of CHOICES nutrition factsheets. The factsheets contain healthy eating advice and entertaining graphics to help educators provide clients with current and useful nutrition information.

The factsheets are available in English only and are two-sided masters designed for

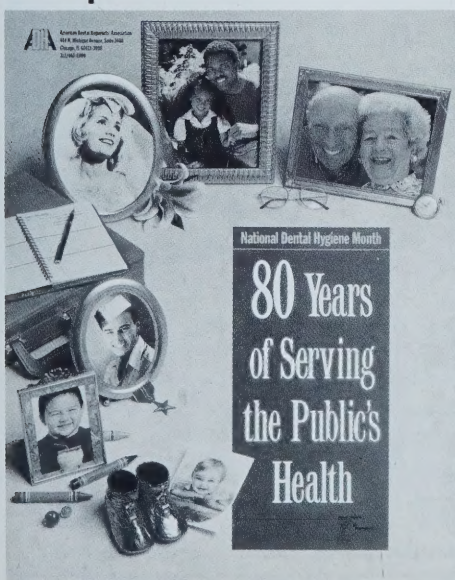
easy duplication. The six factsheet topics for this year include: food safety, healthy body image, nutrition and HIV infection, preconception nutrition, preschool nutrition and reliable sources of nutrition. To subscribe, send a cheque for \$37.45 (\$35 + GST) payable to the Canadian Dietetic Association, 4809 University Avenue, Suite 601, Toronto, ON M5G 1V2.

ADHA Celebrates Its First Dental Hygiene Month

October 1993 was designated National Dental Hygiene Month by the American Dental Hygienists' Association — the first ever held in the U.S. Thousands of dental hygienists across the United States coordinated and sponsored community-based activities to commemorate "80 Years of Serving the Public's Health", the theme for their professional association's first annual National Dental Hygiene Month.

Throughout the month of October, dental hygienists from state and local dental hygiene associations organized activities such as health fairs, tooth-brush trade-ins at shopping malls and oral healthcare presentations at schools and senior centres. Their main objective was to focus public attention on the importance of preventive oral healthcare and the role dental hygienists have had in providing 80 years of quality preventive care to the nation's health.

For the past six years, dental hygienists in the USA and Canada have sponsored events during the third week in October. 1993 marks the first observance scheduled for the entire month of October. Highlights of the NDHC will appear in the next issue of *Probe*.



Dental Hygiene Schools Canvassed to Assess Interest in Developing Exchange Program

The Allied Dental Educators' Committee, a committee of the Association of Canadian Faculties of Dentistry (ACFD), forwarded an 'interest questionnaire' to all accredited dental hygiene programs (and other dental programs) in September 1993. Faculties at the educational institutions had the opportunity to indicate their interest in a faculty and/or student exchange program. The information will be tabulated and distributed in the future so that interested parties can make contact and discuss the strategies for developing viable exchange programs.

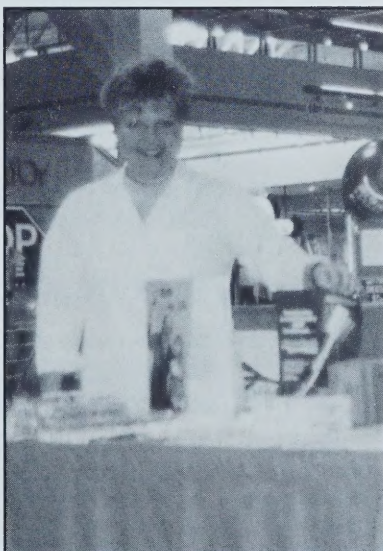


Photo Correction

The person shown in the information booth above was mistakenly reported as Sharon Milroy in *Probe's* September/October issue. That person is actually **Stephanie Bradley** of Moncton, NB. Sorry, Stephanie!

ADHA 1993/94 Elects New President

During its 70th Annual session held in Denver, Colorado in June 1993 the American Dental Hygienists' Association installed new officers to serve on its Board of Trustees. Sarah A. Turner, RDH, MAE of Waterloo, Iowa was installed as President.

Ms. Turner brought greetings from the ADHA to participants at the 4th Annual CDHA Professional/Research Conference in Niagara Falls. She congratulated the CDHA on efforts for holding the Conference as a means of sharing the vision that Dental Hygiene is a profession which includes: a call to the profession service orientation, extensive education, a code of ethics, research, self-regulation, autonomy and membership.

"Autonomy is such a simple concept really, — simply taking responsibility for one's actions... Vision without action is merely a dream. Action without vision just passes time. Vision with action can change the world."



Report on the CDHA/CFDE/ACFD Strategic Planning Session for Dental Hygiene

In March 1992, the Association of Canadian Faculties of Dentistry, Allied Dental Educators' Committee (ACFD/ADE) implemented a strategic planning session related to dental hygiene educational standards through CFDE funding. Concurrently a similar workshop was held for dental assisting educational standards. The collaborative approach allowed for sharing of strategies and ideas, and also provided opportunities for the two groups to work on the specific tasks. The workshop was facilitated by Sheryl Feller and the representatives in the dental hygiene group included: Susan Barry, Licensing Body Representative; Louise Bourassa, Community Colleges Representative; Dianne Gallagher, Wendy Halowski, CDHA Representatives; Bonnie Craig, University Program Representative; Susan Matheson, Commission on Dental Accreditation Representative and Susanne Sunell, ACFD Representative.

The group explored issues relating to educational standards as they were integrated into the practice of the profession, entry into the profession, regulation, and concepts of continuing competence. The overlap of elements emphasized the interdependence of areas, and the need to develop a coordinated approach for a document which would be of benefit to educators, professional organizations, licensing bodies, accreditation review personnel, and the public.

Three basic questions were addressed during the workshop: Where are we now? Where do we want to go? How are we going to get there? Using the elements of a profession as a guideline and SWOT (Strengths, Weaknesses, Opportunities and Threats), as a matrix for discussion, the group prepared a profile to assist in the strategic plan. They concluded that the CDHA would be the most appropriate group to develop a self-definition of the profession, and to revise dental hygiene standards which go beyond the clinical focus to include education standards. Self-definition, practice standards and educational standards will then form the basis for guidelines for regulatory bodies to estab-

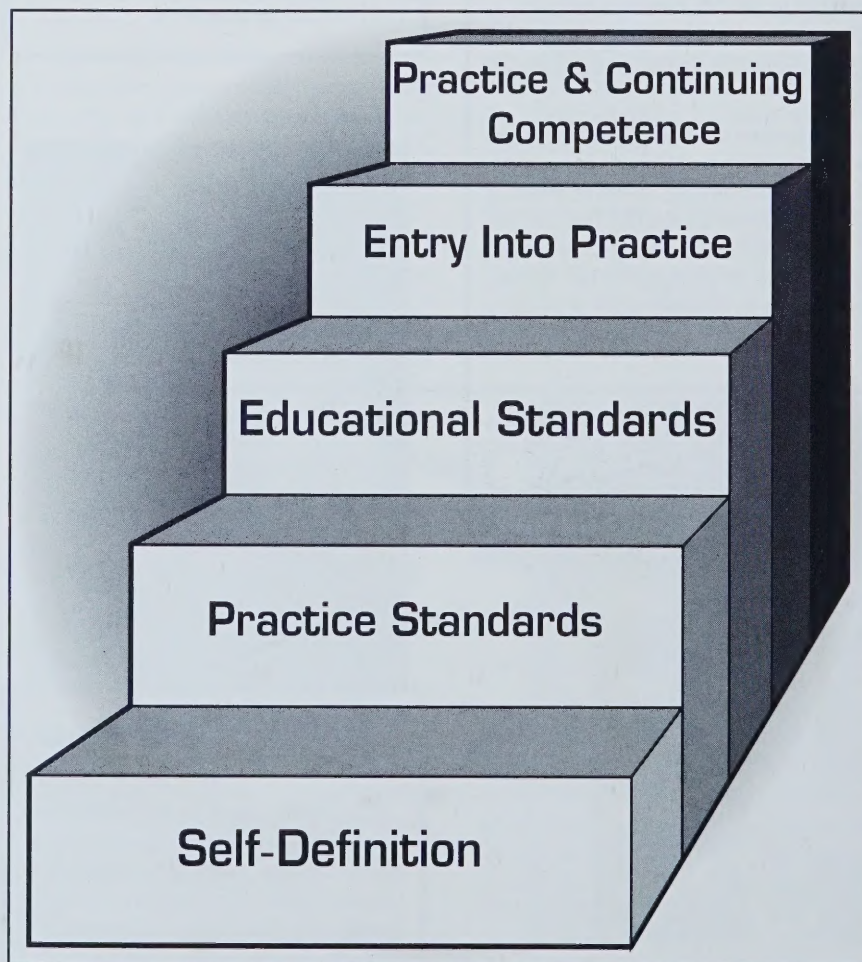
lish entry into practice and continuing competence regulations. The following diagram represents the vision which was developed to reflect the strategic planning process.

The final report from the workshop explains the vision and the action plan to implement this vision, in detail. It has been widely distributed in French and English to professional associations, licensing bodies, and educators. Several of the strategies have already been acted upon by the CDHA and ACFD. The CDHA has developed a draft document relating to professional self-definition and revised dental hygiene practice standards. ACFD has initiated a teaching conference on curriculum guidelines through CFDE funding. This conference will be scheduled in conjunction with a CDHA workshop on education standards which will be held during the CDHA

Professional Conference in June 1994 in Saskatoon.

The strengths which could evolve from a continued collaborative approach to strategic and operational planning was an important revelation of the workshop. The parallel development of the dental assisting and dental hygiene professions was obvious to all. The two groups shared similar challenges and windows of opportunity to the evolution of their national visions. The overall impact of this workshop will be evident from the activity which will occur throughout the stakeholder organizations over the next several years.

Thanks to Susanne Sunell, Workshop Coordinator for submitting this report.



The CFDE and the Dental Hygiene Profession

As a dental hygienist you know that collaboration is crucial to the smooth operation of all dental offices. But it doesn't stop there. Collaboration is just as important outside of the dental office as it is inside. For years the Canadian Fund for Dental Education (CFDE) has also been working, often behind the scenes, with dental hygienists as a part of *their* team.

As a fund-raising group for the dental profession, the CFDE receives voluntary donations from dental industry, the profession and businesses. Since its start in 1962, the CFDE has raised over three and a half million dollars for dental education and research. The funds have permitted the CFDE to support many programs important to allied dental health professionals including fellowships for hygiene and dental assisting teachers, numerous conferences and meetings, and the re-opening of a community college's dental hygiene program.

Over the past 30 years the CFDE has granted a total of \$109,750 for dental hygiene teacher/researcher training fellowships. In all, 57 recipients have benefitted from CFDE assistance. This support has enabled individual hygienists to upgrade their qualifications by continuing their university or college education or to conduct relevant research.

For example, in 1993 a grant to community dental health hygienists at an extended-care facility for seniors permitted them to research the problems faced by residents whose oral health care may be

neglected because of other serious health concerns, the inability to perform self-care, or the lack of time, knowledge or motivation of caregivers. As a result, an appropriate oral health care educational program was developed and implemented for the caregiving staff at the facility.

As well as fellowship support to individuals, dental hygiene programs that benefit everyone also receive CFDE funding.

In 1992 the reinstatement of the dental hygiene program at Niagara College, Welland Campus was made possible by the generous donation of dental equipment valued at \$22,133 by CFDE corporate donor SciCan, Division of Lux & Zwingenberger. The program, originally suspended in 1988, reopened last year with an enrolment of 27 students.

The Allied Dental Educators' Committee of the Association of Canadian Faculties of Dentistry (ACFD) received a grant of \$16,020 last year. The funds supported planning sessions held March 4-5, 1993, for the revision of the national dental hygiene and national dental assisting competency documents.

In all, the CFDE granted \$46,153 to dental hygiene programs in 1992.

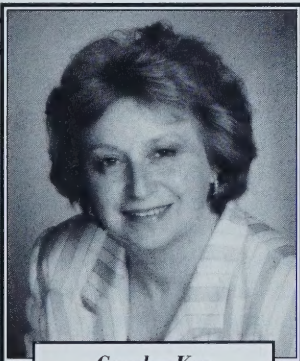
This year the Canadian Dental Hygienists' Association "North American Research Conference" that was held in Niagara Falls in October, received \$6,000 in CFDE support. The conference brought together dental hygiene

researchers, educators, practitioners and others interested in dental hygiene research. The subject areas addressed included advances in clinical techniques and technology, disease prevention/health promotion and theory development and testing.

The CFDE's future commitment to dental hygiene includes a \$10,000 allocation to the 1994 ACFD/Allied Dental Educator's "Teaching Conference on the Development of Educational Standards for Dental Hygiene." This two-day workshop will focus on the development of national educational standards for dental hygienists based on an action plan developed during the strategic planning session for the revision of the national dental hygiene competency document.

Donations from hygienists and other allied dental health professionals help the CFDE support these programs. In fact, a few years ago, the Canadian Dental Hygienists Association Endowment Fund was established to benefit dental hygiene in Canada. At the end of 1992 the balance of the Fund stood at \$3,500. As a dental hygienist this is your fund — an investment in your future. Your contribution will benefit programs that affect you directly. As a team, the CFDE and dental hygienists can work together to promote and improve oral health for all Canadians.

Please send in your contribution today to the Canadian Fund for Dental Education — CDHA Endowment Fund, 1815 Alta Vista Dr., Ottawa, ON K1G 3Y6.



Carolyn Kay

Dental Hygienists Awarded CFDE Fellowships

Three dental hygienists received Canadian Fund for Dental Education (CFDE) teacher/researcher training fellowships for the 1993/94 academic year. CFDE Board of Trustees approved the awards at its annual meeting in May.

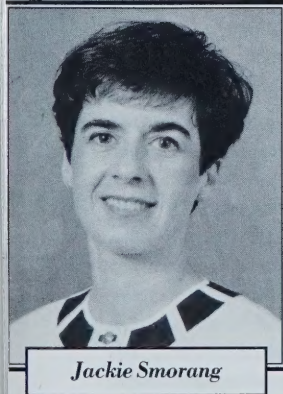
Dental hygiene teacher, Carolyn Kay, of Willowdale, Ontario received for a second year, a CFDE teacher/training half-fellowship in the amount of \$1,400. Ms. Kay is studying for a Masters in Education, with a specialization in health professional education and curriculum design and development, at the Ontario Institute for Studies in Education (OISE). She also teaches part-time in the dental hygiene department at George Brown College.

Ms. Kay says she is fortunate to be able to continue her studies at OISE: "I believe the possibilities for applying so much of what I have learned are clear: As dental hygiene undergoes changes to practice, educational programs will

undoubtedly also experience re-evaluation and adjustment. I look forward to being able to continue to participate as an educator in these challenging times."

Also for the second consecutive year, Jackie Smorang and Janet Erikson of Foothills Hospital in Calgary, Alberta shared the Warner-Lambert sponsored fellowship for a hygiene teacher and/or community health dental hygienist. They received \$2,500 to support their joint project "Surveying Oral Health at an Extended-Care Centre".

Their project identifies the problems faced by individuals in hospitals, nursing homes and other facilities whose oral health care may be neglected because of other serious health problems, the inability to perform self-care, or the lack of time, knowledge or motivation of caregivers. By developing and implementing a mouthcare survey, Ms. Smorang and Erikson were able to evaluate caregivers' mouthcare knowledge, attitudes and practices. Information obtained from the survey permitted them to devise and conduct an appropriate educational program for staff.



Jackie Smorang



Janet Erikson



Haven't We 'Eased' Floss into Our Oral Hygiene Instruction Long Enough?

By:
Theresa Zinck, RDH

Introduction

In 1815, Levi S. Parmley wrote in his book *The Summum Bonum*,

"Though we should be careful to clean the teeth after every meal, it is more particularly necessary before retiring to rest; the foulness which has been all day accumulating, is thus prevented from committing its ravages during the night. A hard open brush with a composition made into a paste, is preferable to any powders yet known; it should be used at night, **after which a waxed thread should be passed between all the teeth, for the purpose of cleaning them**, a particular experience is our best instructor.

When the gums are spongy, and liable to bleed from the slightest touch, persevere, though apt to occasion much bleeding at first, eventually gives much firmness, and in short time effects a cure."¹

Generally, clients believe flossing and the idea of interdental cleaning, is relatively new. Most are surprised when told that dental hygienists have been trying to educate people to clean all sides of their teeth since the early seventies. The above quote shows us that the idea had been introduced as early as 1815 — which is more than 170 years ago!

In 1965, when I took my training in dental hygiene, dental flossing was something that dental hygienists did after polishing a client's teeth to remove the residual grit. Flossing was considered too difficult for clients to practice on themselves, and, at that time, there were generally few strong scientific reasons to educate clients to do so.

In the late sixties continuing education courses began to suggest that periodontal clients fared better if they could be taught to use dental floss after surgery to prevent further disease. In 1970, the increased use of fluoride applications after a dental prophylaxis had the effect of preventing the occurrence of dental caries. These two factors coupled with the increase in the number of teeth our aging population were retaining, indicated that periodontists were facing a daunting increase in the incidence of periodontal disease. It was then suggested that the dental hygiene profession should introduce flossing to all clients.

For the past twenty-plus years, we have continued to introduce floss and flossing to our clients. Probably most of your clients know what floss is by now. However, it is possible that many people have not "internalized" flossing as being part of the process of 'cleaning one's



Theresa Zinck, RDH

teeth'. If this combination of flossing and brushing were internalized in a person's childhood, then flossing would not be considered an extra job to be done 'sometime' or at least 'once a day'.

Another excerpt from *The Summum Bonum*, says:

"The teeth which are intended by nature to be permanent, having made their appearance, require the assiduous attention of the parent, until the faculties of the child are sufficiently matured to be enabled to attend to the task itself; 'the importance of attention to the teeth, should be inculcated with their [the children] earliest lessons, and an impression thereby made that will not be forgotten in manhood [adulthood], and, which will secure to themselves a sound, even set of teeth until with their body they decay in the grave'.²

A. Definition

Webster's dictionaries define *Dental Floss* as a thread for cleaning "between the teeth". This definition shows that we have not done a very good job of educating the majority of the public about what, in fact, dental floss really cleans. The difference in cleaning **between** the teeth and cleaning **the side of the tooth inaccessible to the toothbrush** is more than semantics. A client takes our words very literally. If we say that floss, or another interdental aid, cleans "between" the teeth, very likely the client will only try to remove debris from the interdental space itself. This process does not address the interproximal tooth surfaces where effective flossing will disrupt the adherence and accumulation of bacteria.

B. Goal of Instruction

Every message we send out as 'professionals' affects not only the person we are speaking to, but also the people with whom that person interacts within his/her generational circle — for example, spouses, parents, and children. Dental floss and other interdental aids instruction has been part of oral hygiene education for at least the past 25 years, but, on the whole, today's generation still does not appear to effectively practice what they have gained in knowledge from the two previous generations. If we recommend that people clean their teeth every 12 to 24 hours for optimum health without damage from abrasion, then **our goal of instruction would be for interdental cleaning and toothbrushing to be a single procedure, done every 12 to 24 hours.**

C. Strategies for Instruction

When we try to change a person's oral hygiene habits, our teaching strategies **must** take into account the psychology of the causes and effects of attitude on habits. If our teaching strategies leave room for 'inference by implication', the message that we try to send may not resemble the message the client receives. For example, we might say it is necessary to brush twice a day but it is okay to floss only once a day, or a couple of times a week. If we do not explain the interdental area's derived cleaning benefit by linking to the brushing process, by implication (or omission), the message is inferred that flossing is optional. If, on the other hand, the client is shown the benefit of the physical aspect of both the brush and the floss on plaque removal, and is encouraged to believe that **a tooth not flossed is a tooth not cleaned**, then the message received should be closer to the intention of the message sent.

One strategy, which has been successful in implementing this philosophy, is to encourage the client to always start the 'cleaning the teeth' process with flossing so that s/he can still complete the job with the familiar brushing process that we all learned as children. Known as the 'primacy effect' within the psychology of learning, it has been shown that one remembers what is heard or done first when learning a new instruction as compared to what one hears in the middle or at the end of an instruction. However, one must also take into consideration what is known as the 'recency effect'. Studies have shown that an even larger percentage of learners remember what is heard or done last better than what is heard or done first. Because of individual differences, both techniques of instruction should be used. It should also be noted that inserting a new instruction in the middle of a learning situation greatly reduces the likelihood of the recipient remembering the instruction at all.³ Therefore, if we teach "**floss, then brush**" as a technique for cleaning the teeth, then we are improving the chances of a more complete dental cleaning taking place.

D. Outcomes of Current Educational Practice

In this decade of the nineties dental hygiene has been focusing on many of the dental problems that seniors currently face. While the good news is that only 15% actually exhibit severe periodontal disease, the bad news is that 85% of that disease is in the col area. For those who do not get severe periodontal disease there is a possibility of some inflammation at the col area, which in turn, could be more easily damaged by incorrect techniques when brushing, even with a soft brush. If clients are not flossing, the col area will become inflamed and be subject to damage from the brush because of the col area's increased size. Brushing without flossing or other interdental cleaning, can not access the col area. The toothbrush contacts only the outside of the tissue and does not effectively remove the bacteria from the tooth under the col area. It is possible for toothbrush bristles to damage inflamed tissue in the col area without ever cleaning the tooth under the tissue. A large percentage of seniors who do not have periodontal disease do have severe abrasion and increased risk of root caries. Abrasion is generally attributed to excessive and/or aggressive toothbrushing. It can be concluded that this happens most often because people have tried extra hard to make their teeth 'feel clean'. However, teeth that are brushed to 100 percent perfection can only be 60 percent clean — i.e. three out of five surfaces. The combination of bacteria buildup from lack of interdental cleaning and incorrect brushing techniques can contribute to recession.

More emphasis needs to be placed on the prevention of disease by encouraging total tooth cleaning. Techniques that include regular and timely flossing, the use of other necessary interdental aids, combined with the brushing of the teeth must be emphasized in the instruction. The important root surfaces would, in most cases, then be left buried under skin and bone. (Although abrasion from over-exuberant brushing is still possible.) Root caries and periodontal disease could become a phenomenon of the early 1990s.

E. Summary

We have tried to 'ease' the procedure of dental flossing into the job of cleaning the teeth long enough. Almost all our clients know about the benefits of flossing and that they are supposed to floss. What we have not been successful in teaching is that it is not an option; it is an integral part of complete plaque removal. Developing and utilizing new methods of instruction to increase the overall effectiveness of our dental hygiene education, with the objective of decreasing the occurrence of periodontal disease, is then, our challenge.

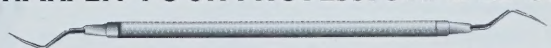
References

1. Parnley, Levi S. *The Summum Bonum*. J. Neilson, Mountain St., Quebec, 1815, pp. 5-35.
2. Ibid.
3. Houston, John P. *Fundamentals of Learning and Memory*, Third Edition. Harcourt Brace Jovanovich, Inc., New York, 1986, p. 276.

About the author: Theresa Zinck resides in Halifax, Nova Scotia. She received her diploma in Dental Hygiene in 1967 from the School of Dental Hygiene, Dalhousie University in Halifax, NS. She has over 25 years of experience in both public health and private practice. Presently she is a part-time instructor at the School of Dental Hygiene at Dalhousie.

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Seniors

Packages

- I "Oral Health in the Elderly: A Workshop Curriculum and Teacher's Guide" (2 available)
- II "Oral Health Education for the Elderly...A New Preventive Dental Care Program" (1 available)
- III "Training and Motivational Materials in Geriatric Dentistry" (1 available)

Manuals

- IV "Geriatric Oral Health: A Training Manual for Long Term Care Facilities" (2 available)
- V "Assessing the Aging Mouth" (1 available)

Slide-Script Set

- VI "Senior Smiles" (2 available)

Videotapes

- VII "12-Minute Videotape (VHS) for the Elderly" (In French only — 2 available)
- VIII "Options: Dental Health in Later Years" (2 available)
- IX "The Senior Smile" (2 available)
- X "Oral Health and the Elderly" (1 VHS available)

Special Needs

Slide-Script Set

- I "Prevention and Treatment Considerations for the Dental Patient with Special Needs"

Children

Videotapes

- I "Toothbrushing with Charlie Brown" (2 available)
- II "It's Dental Flossophy, Charlie Brown" (2 available)
- III "The Barnyard Snacker" (2 available)
- IV "The Haunted Mouth" (2 available)

Other

Videotapes

- I "Fluoride — The Magnificent Mineral" (2 available)
- II "Fantastic Fluoride" (2 available)
- III "Oral Problems of Patients with AIDS and HIV" (1 set available in English/ 1 set available in French)
 - Part I a) Dr. Norbert Gillmore
b) Mr. Rick Hatt
 - Part II "The Global Occurrence of AIDS"
 - Part III "HIV Associated Periodontal Disease"
- IV "Prescription for Periodontal Health" (2 available)
- V "More Than Just a Pretty Smile" (1 available)
- VI "Dentistry Update" (1 available)

New Acquisition

Community Action Pack

This comprehensive package was purchased on the request of the members of CDHA's Health Promotions Council. The package includes:

- ▲ a community action pack video
- ▲ an 'ideas' file
- ▲ a guide to the Community Action Pack
- ▲ a resource directory
- ▲ a contact list
- ▲ a log book
- ▲ a health communities video describing how the residents in 5 areas of Newfoundland took action to improve their communities
- ▲ a health promotion magazine
- ▲ a project planning manual (binder) which includes a set of four workshop outlines to walk a group through the steps involved in getting started, doing a needs assessment, planning goals and activities, and evaluating.

In addition, the package includes three resource modules:

- Red** — Acting for Community Health
— Assessing Community Needs
- Blue** — Making Plans
— Finding Resources
— Managing Relationships
- Orange** — Making it Happen
— Evaluating

Canadian Dental Hygienists Association Community Health Audiovisual Aid Library Order Form

Notes to the Borrower:

- 1) All audio visual materials on loan through the Canadian Dental Hygienists Association are under strict copyright infringements, and **may not be reproduced.**
- 2) All materials obtained through the CDHA Audio Visual Library are on a **loan basis only.** Should you wish to inquire about the purchase of these materials, please do so through the original source.
- 3) A **Visa number must be provided** for each individual information package request. This would be used to cover a \$10.00 shipping and handling fee accompanying each package.
- 4) The maximum lending period is **twenty one days.** You will be informed of the value of the package and its return date upon receipt of your order. It is solely the borrowers responsibility to **return the package to Central Office prior to the expiry date.** Failure to comply will result in a fee applied to the visa account in the amount representing the value of the package. **It is imperative** the borrower have the package insured with Canada Post prior to return mailing, as **The Canadian Dental Hygienists Association will not assume responsibility for loss or damage.**
- 5) Should you have any suggestions for library acquisition or you would like to place your order by phone please contact: Donna Awrey, 1018 Merivale Rd. Suite #201, Ottawa, Ontario, K1Z 6A5 or by phone at 1-800-267-5235.

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Required date for receipt of material: _____

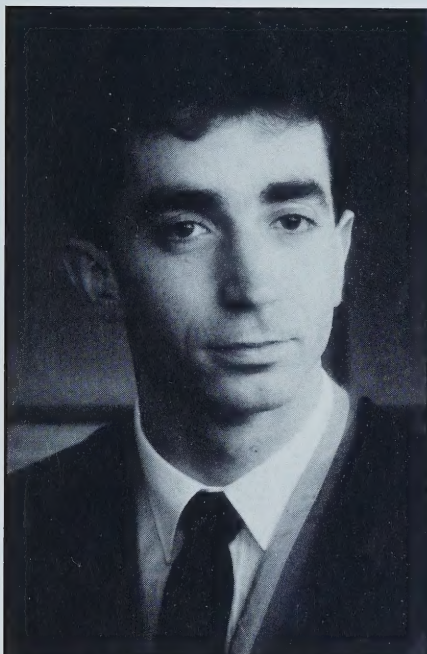
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Note: It is important that the complete order form, with the contract wording, is returned.



Student Scene



Paul Green, RDH, BScH



Christy Cessford, RDH



Natasha Kravstov, RDH

1993 AquaFresh Scholarship Winners

The AquaFresh Scholarships are presented to first and second-year dental hygiene students for their contributions to the advancement of the dental hygiene profession. This year's recipients were chosen from nine dental hygiene students who submitted applications for consideration in the awarding of the scholarship which is valued at \$1,000.00.

Paul Green graduated from Confederation College in Thunder Bay in 1993. He also has a BScH in Life Sciences from Queen's University, Kingston. Throughout his studies he has been involved as a medical relief worker in Guyana, in community dental hygiene projects, as a peer tutor, and a volunteer in the Canadian Ski Patrol. He is presently working as a dental hygienist in private practice in Delta, BC.

Christy Cessford and Natasha Kravstov are 1993 graduates of the University of Manitoba's School of Dental Hygiene. As students, both represented their classmates on

CDHA gratefully acknowledges the sponsorship of this annual award by
SmithKline Beecham Co.

Student Councils, were student representatives to the Manitoba Dental Hygienists Association, actively participated in the National Dental Hygiene Campaign and conducted entrance interviews for the School of Dental Hygiene. Ms. Cessford and Ms. Kravstov are presently working in private practice in Winnipeg, Manitoba.

University of Manitoba Dental Hygiene Students Participate in 1993 National Dental Hygiene Campaign

As an assignment for the Community Health Course, dental hygiene students at the University of Manitoba prepared scripts for HEALTHLINE, a library of tape-recorded messages on a variety of health topics. The public can access the tapes by asking the operator for a tape number/topic as listed in the Winnipeg telephone directory.

The purpose of the assignment was to give the students an opportunity to experience what it is like to actively participate in CDHA's National Dental Hygiene Campaign says Professor Laura MacDonald, the instructor who created the assignment. The overall theme for the CDHA's National Dental Hygiene Campaign is "Hygienists Helping People" and this year the campaign focussed specifically on school-aged children. Students were expected to develop a 3-5 minute script on a specific oral health topic. The information was to be supported by at least five references.

HEALTHLINE is a great success story in Manitoba. It was founded by the Manitoba Medical Association in collaboration with Manitoba Health. The Luther Home, a residential home for persons with disabilities is the home base for Healthline in Manitoba. Young residents with physical disabilities are paid employees (the operators) for the program. According to the Manitoba Department of Health, Healthline receives 70-75 requests for information every day. Perhaps other hygienists can borrow the idea and create a Healthline in their community.

**NEW CLINICAL REVIEW ENDORSES
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Journal of the European Organization for
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...LIKE FLUORISTAT IN CREST.¹

On June 3rd 1993, the results of a clinical review by independent dental research scientists, were released. The scientific advisory group showed that, when all the relevant worldwide data were analyzed, NaF (sodium fluoride) in a compatible abrasive system was found to be significantly more effective in preventing caries than SMFP (sodium monofluorophosphate) dentifrice ($p < 0.01$).¹ As a consequence, dentists should be recommending dentifrice containing NaF in a compatible abrasive system.¹ CREST contains *FLUORISTAT*, a formulation comprising NaF and a highly compatible silica abrasive system. In fact, it's been estimated that Canadian children who start at age seven, could experience 20% fewer cavities by the time they reach 20, by using CREST with *FLUORISTAT* instead of a dentifrice with SMFP.²

RECOMMEND



IT CAN MEAN 20% FEWER CAVITIES²

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References 1. Stookey GK et al. *Caries Research*, June 1993.

Applies for equal total fluoride levels versus SMFP.

2. Procter & Gamble, data on file based on mathematical model in:

Kingman A. *Caries Research* 1993; in press.

P A A B





CANADIAN DENTAL HYGIENISTS ASSOCIATION

5th Annual Professional Conference

June 17-19, 1994 • Delta Bessborough Hotel • Saskatoon, Saskatchewan



SHARPEN YOUR PROFESSIONAL EDGE:



"A Question of Conscience – A Matter of Choice"

As the Dental Hygiene profession seeks and obtains self-regulation through provincial legislation, we must be ready and willing to accept all of the legal, ethical and moral responsibilities that accompany this accountability.

To this end, CDHA's Board of Directors has, or is in the process, of reviewing, revising and implementing a Code of Ethics, Standards of Practice and Education, and a National Certification Process. While these documents will provide concrete guidelines for dental hygiene practice, the overt actions that ultimately result are subject to the conscious choice of each individual hygienist.

Ethical dilemmas and/or ethical distress cannot always be resolved by reference to a rule or guideline. Inevitably the dental hygienist must consider the specific circumstances of the case in question and must reconcile their actions with their conscience when caring for clients.

The 1994 CDHA Professional Conference will provide a timely opportunity for hygienists to explore the dilemmas, increase their knowledge and expand their perspective through the dynamics of interaction with the experts and colleagues.

As hygienists become more aware and confident in their abilities to make sound moral and ethical judgements and decisions, the quality of client care dramatically improves.

It is your responsibility as a health care professional to "Sharpen your edge".

HERE ARE A FEW OF THE SPEAKERS WHO ARE LINED UP TO ADDRESS YOU IN SASKATOON NEXT JUNE:

Brent Cotter — Deputy Minister of Justice and Deputy Attorney General — Province of Saskatchewan

"Dental Hygiene and Health Care: Coming to Terms with the Ethical and Moral Dilemmas"

The ethical universe of professional service providers is a complex one. This presentation will present the complexity of the universe, and describe its specific operation in the area of the delivery of dental hygiene services. Mr. Cotter will present a model which orders the competing demands as priorities and then examine specific ethical dilemmas faced by dental hygienists and propose specific resolutions to the dilemmas — based on the use of the model. Finally, the presentation will address the shortcomings in these resolutions and examine system-wide options which can address at least some of the shortcomings.

About the presenter:

Brent Cotter is Deputy Minister of Justice and Deputy Attorney General for the Province of Saskatchewan. He is presently on leave from the Faculty of Law, Dalhousie University, Halifax, Nova Scotia. He is a visiting professor at the University of Alberta, has worked as a labour arbitrator and consultant. He is the co-author of *Employment Law in Canada*, 2nd ed. and author of "Enforcing the Human Rights of the Poor", a chapter in *Discrimination and the Law and the Administration of Justice*.

Michael Rachlis, MD, MSc, FRCPC

"Saving Medicare — The Power and the Glory"

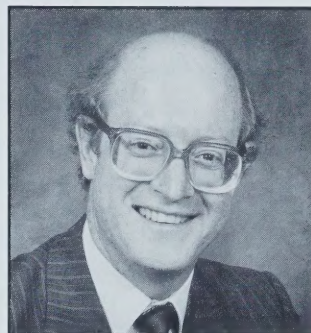
Canadians have become convinced that medicare is in big trouble. However, many proposed cures for medicare's woes would, in fact, kill the patient. Public health insurance costs less than private insurance and covers everyone. Private insurance would cost more and cause gaps in coverage and a multi-tiered system of care. It is the **delivery** system which needs serious reforms. Canada's health care system is dominated by institutions and key professionals (especially doctors and dentists). It provides very expensive illness-treatment services that are of disparate quality. If Dental Hygienists want to reform the delivery system they need to form coalitions (the power) and push a political agenda which promises better service for the same money (the glory). The failure of repressed groups like dental hygienists to take bold steps today will kill medicare tomorrow.

About the presenter:

Dr. Michael Rachlis is a familiar name to anyone involved with Canada's health care system. He is the co-author of *Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It*, an insightful critique of medicare.

Dr. Rachlis was born in Winnipeg and graduated from the University of Manitoba with his MD in 1975. Dr. Rachlis spent eight years in family practice at Toronto's South Riverdale Community Health Centre and then completed his specialty training in community medicine at McMaster University.

Dr. Rachlis now works as a private consultant in policy analysis and epidemiology. He is also an assistant professor (part-time) in the Department of Clinical Epidemiology and Biostatistics at McMaster University and part-time staff physician at Toronto's Hassle Free Clinic.



Gary Chiodo, DMD

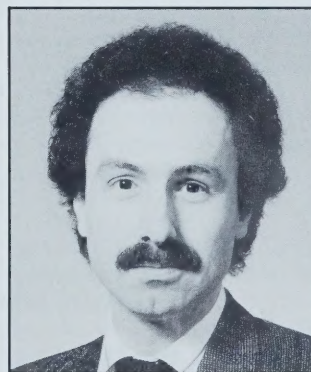
"Applied Ethics in Dental Hygiene Practice: Voicing our Values"

Dr. Chiodo will present three different cases which present ethical dilemmas to practicing dental hygienists. Questions to be discussed will include: 1) Is there an ethical duty to treat HIV-positive patients? If so, what ethical principles support this duty? What are the historical roots of such a duty? 2) What should the dental hygienist do when she encounters inadequate treatment that has been provided by colleagues? Do the ethical duties change when the person providing the faulty treatment is another dental hygienist vs. a dentist? 3) At what point may a dental hygienist ethically refuse further treatment for noncompliant patients? If a patient refuses to improve his oral self-care, should the dental hygienist continue to do what she can or should this patient be dismissed from the practice?

The central questions to be examined in these three cases will be how the dental hygienist's actions may ethically reflect the central values of the profession while not abandoning his/her personal values. This will be a pragmatic discussion that will take the subject of health care ethics out of the lecture room and place it into the clinic, in action.

About the presenter:

Dr. Chiodo is a professor public health dentistry at the Oregon Health Sciences University School of Dentistry. In addition, he serves as an assistant director for the University's Center for Ethics in Health Care. He received his certificate in health care ethics from the University of Washington School of Medicine in 1992. Dr. Chiodo is current co-editor of regular ethic columns in both the *Journal of the Academy of General Dentistry* and the *Journal of the Oregon Dental Association*. He served on the American Dental Association of Dental Schools Working Committee to develop curriculum Guidelines for Blood-Borne Infectious Diseases — Ethics/Behavioural Sciences Section. He is a frequent lecturer throughout the United States, Canada and England on ethical issues and on AIDS-related clinical issues.



Tobelle (Toby) Segal, RDH, BS

"The California Vision (or How a Peace Time Maneuver Turned Into a War)"

Toby Segal will discuss her experience with the establishment of the California HMPP Project #139 — a project designed to increase access to oral health care for underserved segments of the population in California. In her presentation she will address the following questions: Can a trusted professional member of the dental team simultaneously be an undereducated menace to public health? How did four women instigate a project of such scope, how did they implement that project and what did they learn academically and practically? Who and what determined the success (or failure) of the project and how were these decisions reached? Having considered all of the above, should Dental Hygienists stop pursuing the appropriate transfer of technology and go back to being good little girls to keep the peace?

About the presenter:

Toby Segal is a graduate of the University of Michigan, Ann Arbor, class of 1953. She continued her education at the University of California, Los Angeles, Expanded Functions in 1979, and Certification in Health Care Management at California State University, Northridge, 1986-87.

She is past president of the California Dental Hygienists Association and currently serves that association as Trustee representing the San Fernando Valley Component. She is president of Dental Hygiene Associates, Inc., a non-profit public benefit foundation, whose present research project is the alternative practice of dental hygiene. She has been in this position since 1980. She is the administrator of Health Manpower Pilot Project #155, formerly #139, under a grant from the office of Statewide Health Planning and Development of the state of California. She has written extensively on the topics of Independent Practice, Alternative Settings, and the Future of Dental Hygiene and takes pride in being the primary resource for information concerning dental hygiene alternative practice in the United States.





Strategies for Oral Health Maintenance and Disease Control

Situation:

A 34-year old woman is a new patient in the practice where you work as a dental hygienist. Initial assessment reveals a medical history that is essentially negative, a pattern of sporadic dental care, lack of knowledge regarding dental disease, poor oral hygiene, significant amounts of supramarginal and submarginal deposits, generalized gingival recession, flattened or missing papillae in several areas, probe measurements ranging from 5 to 7 mm, Class III furcation involvement on tooth No. 30, and multiple carious lesions. Ten years ago Nos. 3 and 18 were extracted because of caries, but no prostheses were made to replace them. The patient says she is very apprehensive about dental care but wants to have her teeth fixed to look better for an important job interview. During the initial visit she appears uncomfortable and has to go to the bathroom several times. Questions 1-5 refer to this situation.

1. Data collection techniques for this patient included all of the following **except**:
 1. Interview
 2. Observation
 3. Measurement
 4. Examination
 5. Implementation
2. Patients who lack knowledge about the process of dental disease often have poor oral hygiene **because** a learner is helped by early and frequent feedback regarding progress in learning.
 1. Both the statement and the reason are correct and related.
 2. Both the statement and the reason are correct but are **not** related.
 3. The statement is correct, but the reason is **not**.
 4. The statement is **not** correct, but the reason is an accurate statement.
 5. **Neither** the statement nor the reason is correct.

3. Given this patient's gingival architecture and probe measurements, toothbrushing and flossing
 1. Are sufficient methods for controlling plaque.
 2. Alone are **not** sufficient methods for controlling plaque.
 3. Instruction should be delayed until caries control is achieved.
 4. Are contraindicated in the areas of gingival recession.
 5. Techniques are best taught by demonstration on a model.
4. Topical fluoride therapy
 1. Is useless for this patient.
 2. Should not be implemented before the bridges are seated.
 3. Is contraindicated for furcation exposures.
 4. Should be delivered before root instrumentation to prevent hypersensitivity.
 5. Is a valid part of the comprehensive treatment plan for this patient.
5. Fixed prostheses are planned to replace teeth Nos. 3 and 18. The dental hygiene treatment plan should
 1. Not be formalized until the bridges are cemented.
 2. Not be concerned with dental treatment plan.
 3. Include instruction on the proper use of a denture brush.
 4. Include instruction in methods for cleaning pontics and abutments.
 5. None of the above.
6. Patients who do **not** believe that they are personally susceptible to dental disease are **not** likely to
 1. Get a dental disease.
 2. Practice daily disease control.
 3. Develop psychomotor skills.
 4. Need immediate feedback.
 5. Require disease control education.

7. Having patients chart the disclosed plaque in their mouths is an example of
 1. Small step size
 2. Self-actualization
 3. Active participation
 4. Attitudinal motivation
 5. Approach-avoidance reaction
8. Data collection procedures are
 1. The same for all patients.
 2. Determined by patient conditions.
 3. Treatment planned after patient education.
 4. Performed during the implementation phase of care.
 5. Focused on solving the patient's identified problems.
9. Determining the success of a plan for care is the purpose of
 1. Disease control education
 2. Influencing a person's oral health practices
 3. The evaluation component of the dental hygiene process of care
 4. The Periodontal Disease Index
 5. Collecting behavioural data
10. Before patients will become concerned about oral health, they must believe that
 1. Dental disease can be fatal.
 2. Dental disease can have serious consequences.
 3. Dental care is not too expensive.
 4. Dental care is accessible.
 5. Dental decay is limited to children.

Answer Key:

(2) 01 (3) 9 (2) 8 (3) 7 (2) 6
 (4) 5 (5) 4 (2) 3 (2) 2 (5) 1

CDHA extends thanks to Mosby - Year Book, Inc. for granting permission to reprint these questions which are taken from the 'Review Questions' to Chapter 12 (pp493-494) of the text Mosby's Comprehensive Review of Dental Hygiene, Second Edition, edited by Michele Darby and Eleanor Bushee, 1991, Mosby - Year Book, Inc., St. Louis, Missouri.



Report on Dental Health in Canada

From "Canada's Health Promotion Survey 1990 Technical Report" (HPS90), Health and Welfare Canada, 1993. (Released in May 1993) Reproduced with permission of the Minister of Supply and Services Canada.

Highlights

- Eighty-four percent of all Canadians aged 15 and over have one or more of their natural teeth. Canadians who have lost all of their teeth are found in greater proportions among the elderly and the poor.
- Three out of four Canadians (75%) aged 15 and over with one or more of their natural teeth visited a dentist in the 12 months preceding the survey. Ninety-six percent of these Canadians did so for a checkup or cleaning purposes.
- Canadians in higher income groups with higher education levels, in managerial or professional jobs and who are covered by a dental insurance plan are more likely to visit a dentist.
- The vast majority of Canadians (97%) brush their teeth at least once a day. This preventive practice is more widespread among women, younger Canadians and those with higher education and income.
- Seventy-nine percent of Canadians who brush their teeth twice a day or more often also visited a dentist in the 12 months prior to the survey.
- Fifty-six percent of Canadians are covered by a dental insurance plan. Income and education are the two strongest predictors of dental care insurance.
- One out of three Canadians covered by a dental insurance plan did not visit a dentist in the 12 months preceding the survey.

Methods

HPS90 provides information on the dental health status of Canadians, utilization of dental care services, habits of tooth brushing and coverage by dental care insurance. These are new topics since the 1985 HPS.

Section N of the HPS90 questionnaire deals with five key questions related to dental health. The sequence of questions was constructed such that only those who answered "yes" to question N1, "Do you have one or more of your natural teeth?", were asked to provide information on dental visits (N2 and N3) and on the frequency of tooth brushing (N4).

As a consequence, all estimates of dental utilization, expressed as the proportion of individuals who visited a dentist at least once in the 12 months preceding the survey, are based on the subset of the popula-

tion who declared having one or more of their natural teeth. This estimate amounts to 16,924,690 Canadians. In this report, these individuals are referred to as "dentate" Canadians.

For the most part, this report examines the utilization of dental care services by dentate Canadians classified by several socio-demographic and economic variables, such as age, sex, income, education and labour force status. Two other dependent variables, reasons for visiting a dentist and dental insurance, are also examined in relation to other variables.

In an attempt to describe individuals who exhibit a strong predisposition for dental health, a "good oral hygiene" index was constructed from the available data. This index is defined as follows:

- *High concern for dental health:*
brushes twice a day or more often
visited a dentist at least once in year before survey
- *Medium concern for dental health:*
brushes only once a day
visited a dentist at least once in year before survey
- *Low concern for dental health:*
brushes occasionally or never
may have visited a dentist or not

Because HPS90 provides information on dental care utilization for dentate Canadians only, it is impractical to compare dental care utilization rates derived from HPS90 with other national or provincial surveys, as these latter surveys generally asked to question about dental visits during the year prior to the survey of all individuals, regardless of their teeth status.^{1,2,3} Therefore, it is impossible to establish with a high degree of precision national trends on dental care utilization based on the findings of HPS90 compared to earlier data sources.

Results

Canadians with natural teeth

Overall, 84% of Canadians adults report having one or more of their natural teeth. This portion is fairly consistent throughout all provinces, with the exception of Quebec, where 73% of the population are dentate (Table 15-1).

The proportion of toothless persons increases with age, to the point where one out of two Canadians aged 65 and over no longer has any natural teeth (Table 15-1). The proportion of adult Canadians with one or more natural teeth varies considerably by income, starting at a low of 64% among the very poor to reach a high 97% for the rich (Table 15-2).

Dental insurance coverage

Slightly over half (56%) of all Canadians aged 15 and over report being covered by a dental insurance plan. This proportion varies

considerably from province to province. Alberta and Ontario have the highest rates (66-67%), whereas Newfoundland, Quebec and Prince Edward Island have the lowest (40-43%) (Table 15-3).

Dental insurance coverage is fairly consistent from ages 15 to 54, ranging from 63% to 68%, except for those in the 20 to 24 age group, in which only 55% are covered. The rate drops to 43% for individuals aged 55 to 64 and reaches a low of 20% for seniors aged 65 and over (Table 15-3).

The proportion of Canadians with dental insurance increases with level of education. Forty-five percent of individuals with elementary schooling or less are enrolled in such a plan, whereas the rate climbs to 65% for those with a college or university degree. Income adequacy (defined in Table 15a) also appears to be a major correlate of dental insurance. Only 27% of very poor Canadians are covered, but the rate increases with income, peaking at 75% for rich Canadians. Similarly, managers and professionals (70%) are more likely to be covered by dental insurance than blue-collar workers (58%), those who keep house (44%), individuals looking for work (39%) or retired Canadians (25%) (data not shown).

Use of dental care services

Three out of four dentate Canadians aged 15 and over (75%) visited a dentist in the 12 months preceding the survey. This proportion fluctuates from 80% in Ontario to 58% in Newfoundland (Table 15-4).

Whereas the highest proportions of Canadians reporting a dental visit is in the 15 to 19 age group, rates are at their lowest in the 20 to 24 age group. The rates then slightly increase to the 35 to 44 age group and level off. With few exceptions, these trends are fairly consistent from one province to another (Table 15-4).

The proportion of women (78%) who visited a dentist in the 12 months preceding the survey is slightly higher than the proportion of men (72%) (data not shown).

Although the utilization of dental care services appears to be fairly consistent throughout all marital status categories, married women exhibit a greater propensity to visit a dentist (data not shown). The likelihood of visiting a dentist increases as the level of education increases: 84% of dentate Canadians with a university degree reported doing so, compared to 68% of those with elementary schooling (Table 15-5).

Table 15-1

Dentate population (one or more natural teeth), by province and age, age 15+, Canada 1990

Pop. est. (000's)		Dentate population, by age group (%)							
		Total	15-19	20-24	25-34	35-44	45-54	55-64	65+
Total	20,643	84	100	99	96	91	78	65	50
Province									
Newfoundland	434	81	99	100	98	88	71	48	36
Prince Edward Is.	99	85	100	100	98	94	86	67	42
Nova Scotia	697	83	100	100	97	94	78	68	43
New Brunswick	560	80	100	99	95	87	72	61	39
Quebec	5,313	73	100	99	90	81	62	43	33
Ontario	7,636	89	100	99	98	95	88	77	62
Manitoba	834	84	98	100	98	95	75	70	48
Saskatchewan	743	84	100	100	99	97	77	65	49
Alberta	1,862	88	98	100	99	93	81	67	55
British Columbia	2,464	86	100	99	100	93	86	74	54

* Moderate sampling variability; read with caution.

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Table 15-2

Dentate population (one or more natural teeth), by province and income adequacy, age 15+, Canada 1990

Pop. est. (000's)		Dentate population, by income adequacy (%)					
		Very poor	Other poor	Lower middle	Upper middle	Rich	Unknown
Total	20,643	64	65	78	89	97	82
Province							
Newfoundland	434	41*	65	82	92	94	85
PEI	99	55*	63	83	98	98	79
Nova Scotia	697	55	58	82	93	96	81
New Brunswick	560	56	62	77	89	93	80
Quebec	5,313	57	55	70	80	93	68
Ontario	7,636	71	71	82	92	99	89
Manitoba	834	78	71	84	87	99	80
Saskatchewan	743	76	79	83	89	90	75
Alberta	1,862	77	73	84	93	95	81
British Columbia	2,464	75	73	81	91	90	78

* Moderate sampling variability; read with caution.

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Table 15-3

Dental insurance coverage, by province and age, age 15+, Canada, 1990

Dental insurance coverage, by province and age, age 15+, Canada, 1996									
Pop. est. (000's)	Dental insurance coverage, by age group (%)								
		Total	15-19	20-24	25-34	35-44	45-54	55-64	65+
Total	20,643	56	66	55	64	68	63	43	20
Province									
Newfoundland	434	40	46	36	50	49	43	x	x
PEI	99	43	75	x	46	50	49	x	x
Nova Scotia	697	46	68	x	50	61	48	31	x
New Brunswick	560	51	63	46	64	63	54	32	23
Quebec	5,313	40	46	46	51	50	41	22	x
Ontario	7,636	66	76	64	74	81	79	57	25
Manitoba	834	56	70	57	63	66	68	52	x
Saskatchewan	743	45	54	51	62	55	52	28	x
Alberta	1,862	67	67	56	70	79	70	47	63
British Columbia	2,464	58	79	61	65	68	70	52	17

* Moderate sampling variability; read with caution.

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There is a positive association between income and dental visits (Table 15-5). Whereas only 69% of very poor Canadians went to a dentist in the year preceding the survey, rich people are, by far, the greatest users of dental care services (86%).

The findings reported in Table 15-5 also indicate differences in utilization by labour force status. Whereas individuals with managerial or professional occupations exhibit the highest proportion (82%) of dentate Canadians who saw a dentist in the year before the survey, Canadians in the blue-collar group (66%) and those looking for work (72%) are less likely to visit a dentist. Students (79%), retired Canadians (77%), those who keep house (76%) and other white-collar workers (73%) are all close to the average in dental visits.

The proportion of dentate Canadians who visited a dentist is greater among those who were covered by a dental insurance plan: 66% with a plan compared to only 46% of those with no plan (Table 15-6). This trend holds consistently, at varying levels, for each of the ten Canadian provinces.

Reasons for visiting a dentist

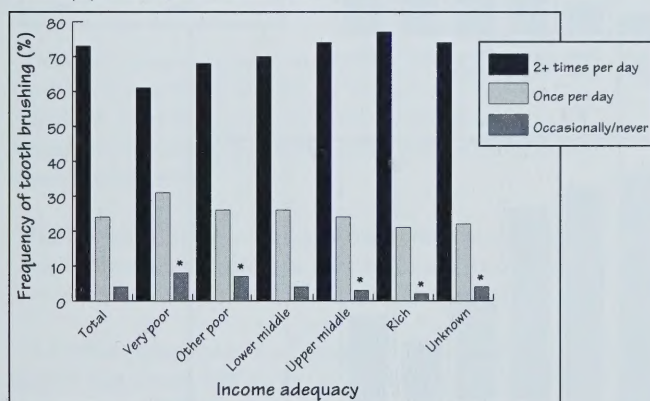
By far the majority (96%) of dentate Canadians aged 15 and over who visited a dentist in the 12 months preceding the survey did so for a dental checkup or cleaning purposes. This reason is relatively consistent among all age groups (Table 15-7).

The second most important reason for visiting a dentist is for a tooth filling or extraction. On average, 42% of Canadians reported visiting a dentist for such purposes (Table 15-7). The very poor are most likely to visit a dentist for a filling or extraction (54%) and the rich least likely (38%) (Table 15-8).

Ten percent of dentate Canadians reported visiting a dentist to have a crown or bridge work done in order to replace, repair or maintain missing or damaged teeth. It is not surprising to observe that this proportion increases with age (Table 15-7), as the proportion of people missing one or more teeth increases with age (Table 15-1). In addition, HPS90 reveals that a greater proportion of Canadians in the highest income group use dental care services for crowns and bridges (Table 15-8). It is quite possible that this finding reflects the greater ability of those Canadians to afford such services.

Seven percent of dentate Canadians received periodontal treatment. The use of these services is greatest among individuals in the 45 to 64 age group. Whereas only 4% of the Canadians aged 15 and over received orthodontic treatment in the year preceding the survey, this dental service is used mostly by teenagers. Only 7% of dentate Canadians reported visiting a dentist as a result of a dental emergency (Table 15-7).

Table 15a
Frequency of tooth brushing, by income adequacy, dentate population age 15+, Canada, 1990



* Moderate sample variability; read with caution.

Tooth brushing

In Canada, the vast majority of dentate Canadians (97%) reported brushing their teeth at least once a day. Furthermore, three out of four Canadians (73%) indicated that they practice this oral hygiene procedure twice a day or more often (Table 15-9).

Although this practice is fairly common in all provinces (Table 15-9), women tend to brush more often (84% brush two or more times a day, compared to 62% for men). Younger individuals are also more likely to practice this oral hygiene procedure more often, although age differences are small (data not shown).

Canadians in the higher income groups are more likely to brush their teeth twice a day or more often (Table 15-A). Similarly, a greater

Table 15-4

Visiting a dentist at least once in the year preceding the survey, by province and age, dentate population age 15+, Canada, 1990

Pop. est. (000's)	Visited dentist, by age group (%)							
	Total	15-19	20-24	25-34	35-44	45-54	55-64	65+
Total	16,925	75	81	67	73	77	76	76
Province								
Newfoundland	349	58	70	58	65	58	43	48
PEI	83	68	82	59	72	68	66	67
Nova Scotia	578	71	79	57	74	78	71	53
New Brunswick	445	69	83	62	68	75	59	71
Quebec	3,848	72	82	65	73	74	73	65
Ontario	6,628	80	82	75	77	81	82	85
Manitoba	677	69	82	56	69	71	73	64
Saskatchewan	608	61	64	54	62	64	46	72
Alberta	1,615	71	83	62	66	77	70	74
British Columbia	2,093	77	85	62	74	78	83	80

* Moderate sampling variability; read with caution.

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proportion of Canadians with higher education levels report brushing their teeth twice a day or more often. Finally, although most of them brush their teeth on a regular basis (once a day), blue-collar workers, those looking for work and retired Canadians are less likely to do so two or more times a day compared to Canadians in other occupational classes (data not shown).

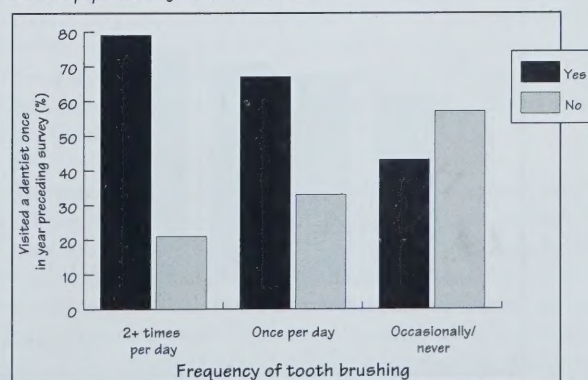
There appears to be a relationship between the frequency of tooth brushing and the likelihood of visiting a dentist during the course of a year. Over three quarters of Canadians who brush their teeth twice a day or more often (79%) also visited a dentist in the 12 months preceding the survey. This proportion drops to 67% for those who brush once a day, whereas even fewer (43%) Canadians who brush only on occasion or never also reported seeing a dentist during the year the survey (Table 15-B).

Canadians who are covered by a dental insurance plan are more likely to brush their teeth compared to Canadians who are not covered (data not shown). Whereas 62% of individuals who are covered by such a plan brush two or more times a day, this proportion drops to 38% for those who are not enrolled in a dental insurance plan.

Canadians who follow healthy lifestyles (defined in Ch. 16) are more likely to brush their teeth twice a day or more often and to make dental visits (Table 15-C). Canadians with a high concern for their oral health. This concern appears to be higher among women than men (Table 5-10)

Table 15b

Visits to a dentist, by frequency of tooth brushing, dentate population age 15+, Canada 1990



Opinions on oral health

Three out of ten Canadians (31%) are under the impression that they can improve their overall health and well-being by taking better care of their teeth. **This means that seven out of ten Canadians do not believe or do not know whether better oral health will improve their overall health status (Table 15-D).**

The proportion of Canadians who believed that they cannot improve their health by taking better care of their teeth is similar among those who visited a dentist in the year preceding the survey (70%) and those who brush their teeth twice a day or more often (67%) (Table 15-D).

On the other hand, Canadians who are less likely to visit a dentist or to brush their teeth frequently are more likely to believe that they can improve their health by taking better care of their teeth (Table 15-D).

Fewer than 2% of Canadians reported that the most important change they made in the year prior to the survey in order to improve their health was to better their dental hygiene. A greater proportion (6%) indicated that they intend to improve their health in the year following the survey by improving their oral health. Sixty percent of the 6% who expressed this intention did not visit a dentist in the 12 months preceding the survey (data not shown).

Table 15-5

Visiting a dentist at least once in the year preceding the survey, by income adequacy, labour force status and education, dentate population age 15+, Canada, 1990

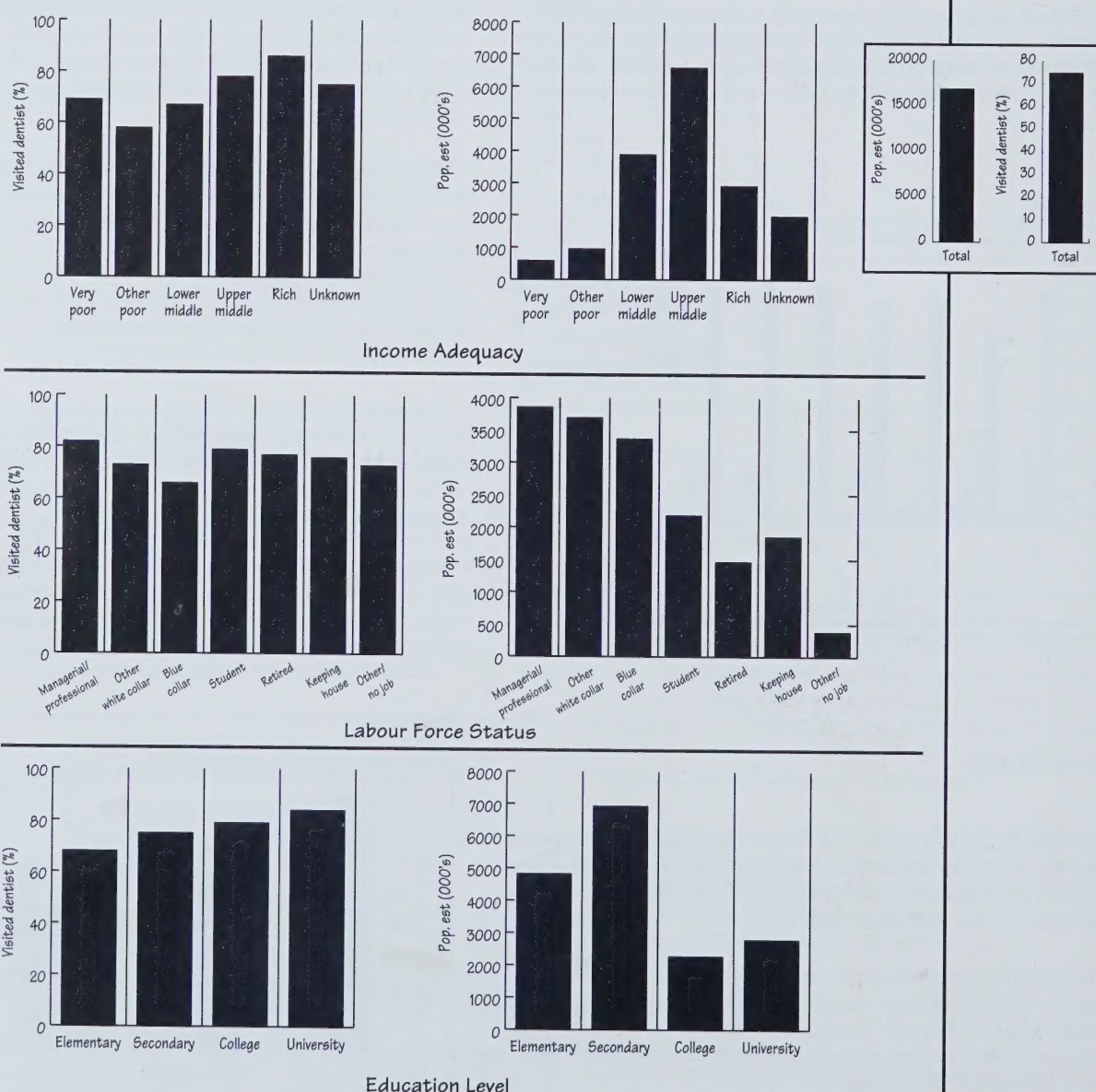


Table 15-6

Visiting a dentist at least once in the year preceding the survey, by province and dental insurance coverage, dentate population age 15+, Canada, 1990

Pop. est. (000s)		Visited dentist, by dental insurance coverage (%)	
		Insured	Not insured
Total	16,925	66	46
Province			
Newfoundland	349	58	29
Prince Edward Island	83	54	37
Nova Scotia	578	59	32
New Brunswick	445	66	44
Quebec	3,848	51	37
Ontario	6,628	74	56
Manitoba	677	66	49
Saskatchewan	608	52	47
Alberta	1,615	77	52
British Columbia	2,093	68	44

* Moderate sampling variability; read with caution.

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Finally, 46% of Canadians feel that it is important for the government to deal with dental health. This belief is shared equally by all types of individuals, whether they visit a dentist or not, or whether they brush their teeth frequently or not (*data not shown*).

Discussion

The use of dental care services

Over the years, several surveys conducted at the national level have examined the use of dental care services by Canadians. Each survey was conducted within its own specifications and limitations and addressed the issue of dental health somewhat differently.

The Canadian Sickness Survey indicated that only 15% of the Canadian population visited a dentist at least once during a 12-month period in 1950 to 1951.

A 1968 supplement to the Canadian Labour Force Survey showed that almost 42% of all Canadians visited a dentist at least once in 1967. The Dental Report published in 1977 by

Health and Welfare Canada examined data collected in 1970 to 1972 as part of the Nutrition Canada National Survey. This report highlighted that almost 50% of Canadian teenagers and young adults visited a dentist once during the course of the year.²

Data from the Canada Health Survey in 1978 to 1979 show that one out of two Canadians visited a dentist at least once during that same year. This proportion drops to 47% when focusing on Canadians aged 15 years and over, regardless of their teeth status. It climbs to 51% for Canadians who do not wear either a full or partial denture (assuming dentate Canadians). In parallel, 9% of Canadians with either a full or partial denture declared visiting a dentist at least once in 1978 to 1979.²

More recently, a Gallup Poll conducted in 1988 on behalf of the Canadian Dental Association showed that 65% of Canadians aged 18 and over made at least one visit to a dentist during that year.⁴ Finally, HPS90 indicates that three out of four Canadians aged 15 and over with one or more of their natural teeth visited a dentist in the 12 months preceding the survey.

With the exception of HPS90, all these surveys measured dental care utilization (expressed by at least one visit to a dentist during the course of a year), based on the total population, for both the dentate and the toothless populations.

Table 15-7

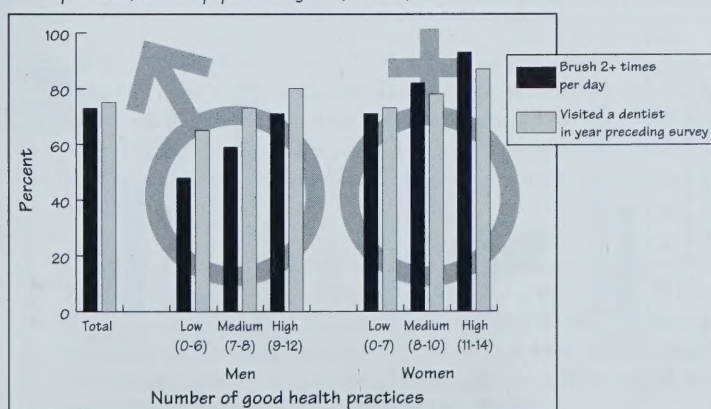
Reasons for visiting a dentist in the year preceding the survey, by age, dentate population age 15+, Canada, 1990

Pop. est. (000's)		Reasons for visiting dentist (%)					
		Checkup/ cleaning	Filling/ extraction	Periodontal treatment	Orthodontic treatment	Crown/ bridge	Dental emergency
Total	12,689	96	42	7	4	10	7
Age group							
15-19	1,485	98	36	x	16	x	5*
20-24	1,293	95	42	x	x	5*	7*
25-34	3,276	96	46	5	3*	6	7
35-44	2,824	96	42	6	2*	12	8
45-54	1,637	96	40	14	x	14	6*
44-64	1,131	96	42	12	x	17	6*
65+	1,043	91	45	7*	x	18	7*

* Moderate sampling variability; read with caution.

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Table 15c
Tooth brushing and dental visits, by sex and number of good health practices, dentate population age 15+, Canada, 1990



As explained earlier, in the absence of data on dental visits on behalf of toothless Canadians in HPS90, it is impossible to establish precise trends in the proportion of Canadians who report visiting a dentist least once during the course of a year. At best, the examination, over time, of other data sources enables us to assume that the proportion of adult Canadians who visit a dentist at least once in a year has been increasing in Canada.

Despite this possible increase, dental care utilization and oral health in general are still marked by inequities. Not all Canadians share equal access to dental care services. In fact, an overview of the findings drawn from the Canadian literature on dental care utilization reveals that the most salient predictors of use have not changed over the years: high income earners, young adults and children, higher educated individuals and women are all greater users of dental care services.^{1,2} The same applies for education labour forces status and dental insurance coverage.^{3,5,6}

Table 15-8

Reasons for visiting a dentist in the year preceding the survey, by income adequacy, dentate population age 15+, Canada 1990

Pop. est. ('000's)	Reasons for visiting dentist (%)					
	Checkup/ cleaning	Filling/ extraction	Periodontal treatment	Orthodontic treatment	Crown/ bridge	Dental emergency
Total 12,689	96	42	7	4	10	7
Income adequacy						
Very poor 401	94	54	x	x	7*	7*
Other poor 558	91	46	11*	x	7*	7*
Lower middle 2,614	93	45	7	5	8	7
Upper middle 5,120	97	42	7	3	8	6
Rich 2,504	98	38	7	x	13	6
Unknown 1,491	95	42	6*	6*	12	6*

* Moderate sampling variability; read with caution.
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Similar findings can be drawn from HPS90: individuals from lower socio-economic groups are more likely to have lost all of their teeth, are less likely to visit a dentist and are more likely to use those services for restorative treatment. They are also less likely to have dental insurance. Although a greater proportion of very poor Canadians (69%) reported visiting a dentist compared to those in the other poor category (58%), this can be explained by the fact that many Canadians in the lowest income bracket may be social welfare recipients. Under the Canada Assistance Plan, these individuals may benefit from additional health care coverage in terms of dental care.

Inequities in oral health are not only a reflection of one's ability to afford dental care services; they are also a reflection of one's knowledge, attitude and behaviour with respect to good oral health in general, and preventive habits in particular (see Ch.19). In this respect, HPS90 indicates that Canadians with less schooling are less likely to visit a dentist compared to their counterparts with higher education.

Oral health status

The only indicator of one's oral health status provided by HPS90 is the presence or absence of natural teeth. This proxy indicator suggests that certain groups exhibit lower oral health status and should therefore be strongly considered for preventive or promotion purposes.

Some studies demonstrate that children from low-income families experience dental decay at an earlier age and have more dental caries, and that older Canadians from the same income groups are far more likely to have lost all their teeth and exhibit more conditions needing immediate treatment.^{7,8,9}

It is quite probable that the greater use of dental care services for filling or extractions expressed by Canadians in the lowest income group (Table 15-8) may be the result of poor dental hygiene habits or a lack of professional preventive care. To a lesser extent, it may also be a result of a nutrition deficiency, given the importance of nutrition and diet in the formation and maintenance of healthy teeth.¹⁰ The relationship between periodontal treatment and age is not really surprising, given that periodontal disease increases with age, its impact being more obvious in older middle age (45 to 59 years).^{11,12}

The promotion of oral health should always be an integral component of the promotion of overall good health. Although oral health problems are rarely life-threatening, they can have signifi-

cant consequences on an individual's quality of life.¹³ Public awareness of the importance of good oral health should be reinforced.

A recent (1988) Gallup Poll shows that, whereas the majority of Canadians brush their teeth on a regular basis, **only 41% believe that brushing helps prevent gum disease. Even fewer believe that flossing or a regular dental visit can help prevent the same disease.**⁴

This shows that, despite the trend toward healthy lifestyles, there is room for improvement in preventive oral health. As expressed by 46% of Canadian adults, it is felt that the government has an important role to play in dealing with dental health issues.

Implications for health promotion

Targets and messages

The findings of HPS90 clearly indicate that the use of dental care services is highly related to income and education. Because cost is a major barrier to dental care services, and because education is a strong pre-disposing factor in assimilating information and knowledge on healthy lifestyles, low-income families and individuals with lesser education represent high-priority target groups in any attempt to reduce inequities in dental care.

Strategies should be developed in order to bring high-risk groups and target audiences into the dental care system by means of greater accessibility and greater exposure to public education and preventive messages tailored to the specific needs of groups or individuals.

Of course, the success of such strategies is highly dependent upon mechanisms implemented to alleviate the cost incurred in seeking dental care services, especially among the economically disadvantaged. In such a context, increasing the accessibility to dental care insurance, especially to the "working poor" and the elderly, is a strategy that needs to be contemplated more carefully. In addition, the benefits of private dental insurance plans, especially those that are employment-based, should be re-examined in conjunction with incentives to make optimal use of these plans, because the enrollment in dental insurance does not necessarily guarantee a more frequent or better use of dental care services by the beneficiaries.

Table 15d

Opinions on ways to improve health status, by visits to a dentist and by frequency of tooth brushing, dentate population age 15+, Canada, 1990

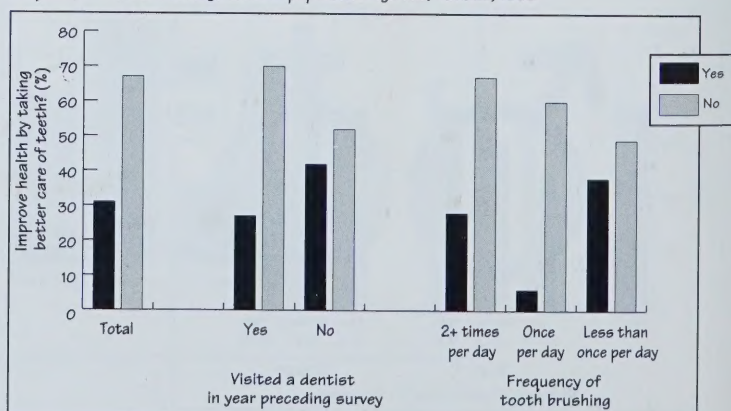


Table 15-9**Frequency of tooth brushing, by province and sex, dentate population age 15+, Canada, 1990**

Pop. est. (000's)		Frequency of tooth brushing (%)		
		2+ times per day	Once per day	Occasionally/never
Total	16,925	73	24	4
Men	8,427	62	32	6
Women	8,498	84	16	1*
Province				
Newfoundland	349	82	16	x
Men	179	71	25	x
Women	169	93	x	x
Prince Edward Island	83	73	22	5*
Men	42	60	30	9*
Women	41	86	14	x
Nova Scotia	578	79	17	4*
Men	290	68	24	8*
Women	288	89	10	x
New Brunswick	445	76	20	x
Men	227	65	28	x
Women	218	87	12	x
Quebec	3,848	73	23	4*
Men	1,902	62	31	7*
Women	1,946	84	15	x
Ontario	6,628	75	23	2*
Men	3,264	64	22	4*
Women	3,363	85	14	x
Manitoba	677	64	29	7
Men	343	50	39	12
Women	335	78	20	x
Saskatchewan	608	53	37	10
Men	312	41	43	16
Women	297	66	31	x
Alberta	1,615	64	30	6
Men	827	52	27	10
Women	789	75	33	x
British Columbia	2,093	76	22	x
Men	1,042	64	31	x
Women	1,052	87	13	x

* Moderate sampling variability; read with caution.
 x Value too small to display

As evidenced by HPS90 findings, a visit to the dentist is no longer associated with only a tooth filling or extraction. By far the majority of Canadians who visit a dentist tend to do so for preventive reasons (a checkup or a cleaning). However, findings in this chapter are consistent with other studies that indicate that individuals who normally undertake preventive health activities are not necessarily the ones in greatest need of such prevention.^{2,14} The same applies to preventive dental health. Because the principal reason for seeing a dentist is for a dental checkup and cleaning, it could be hypothesized that Canadians who brush their teeth more often and visit a dentist at least once a year have a strong concern for preventive oral health and, perhaps, more generally for preventive health overall.

This is confirmed by Table 15-C, which indicates that those with a healthier lifestyle are also more likely to brush their teeth more often and to visit a dentist during the course of a year. These individuals are in the highest socio-economic strata, suggesting that those in the lowest classes should be considered a priority for promoting dental hygiene habits.

Although it appears that the message of frequent tooth brushing has been understood by the majority of Canadians, it is well recognized that dental health promotion is a combination of fluoride use, appropriate brushing and flossing, healthy diet and professional intervention.¹² Perhaps it is time to focus more on the importance of fluoride use, diet and professional care to promote oral health.

Table 15-10**Good oral hygiene index, by sex and number of good health practices, dentate population age 15+, Canada, 1990**

Pop. est. (000's)		Good oral hygiene index (%)		
		High	Medium	Low
Total	16,925	56	15	30
Number of good health practices				
Men	8,427	46	20	34
Low (0-6)	2,466	34	22	44
Medium (7-8)	4,365	48	20	32
High (9-12)	1,596	58	17	25
Women	8,498	65	10	25
Low (0-7)	1,756	54	14	31
Medium (8-10)	6,049	67	9	24
High (11-14)	692	79	6	16

* Moderate sampling variability; read with caution.
 x Value too small to display

Research questions

National polls or surveys should be conducted more often in order to establish major trends in the use of dental care services and other practices. In such a context, the form of the questions, the issues addressed and the population surveyed should be consistent from one survey to another.

Information on dental visits should be collected for all Canadians, regardless of their teeth status. The need for dental care services and the consumption of these services by both dentate and toothless Canadians have to be examined more closely. Whereas the reasons for visiting a dentist have already been documented by major surveys, reasons for not visiting a dentist should be examined in greater depth. More specifically, these reasons should be investigated among those in greater need of dental services and among those who are covered by a dental insurance plan. Very little is known of the perceived need, the demand for and the use of dental services by toothless individuals. It would be useful to pursue research in that direction.

The HPS90 questionnaire did not provide detailed information on other aspects of preventive dental health. Topic such as flossing, dietary habits, fluoride use, frequency of tooth brushing and reasons for these behaviours could be usefully addressed. Attitudes, beliefs and knowledge about preventive dental care also need to be researched in more depth.

Research efforts should also be directed toward the issue of dental care insurance. More needs to be known about the type of coverage, the utilization patterns and the characteristics of Canadians who are covered by dental insurance. Finally, topics such as public insurance for the poor along with other strategies aimed at reducing inequities in dental health are all research avenues that could be focused on.

References

1. Bullen MEB. *The utilization of dental services by Ontario adults, 1979-1980*. MSc thesis. Toronto: Faculty of Dentistry Univ. of Toronto, 1982.
2. Charette A. *Dental care utilization in Canada: an analysis of the Canada Health Survey*. MHA thesis. Ottawa: Faculty of Administration, Univ. of Ottawa, 1986.

3. U.S. Department of Health, Education and Welfare. *Volume of dental visits. Reports from the National Health Surveys*. National Center for Health Statistics, 1965,1970,1981 (Series 10).
4. Canadian Dental Association. Highlights of the CDA's 1988 Gallup Poll: Canadians are getting the message and acting on it. *J Can Dental Assoc* 1989; 55:241-3.
5. Teh-wei Hu. The demand for dental care services, by income and insurance status. *Adv Health Econ Health Serv Res* 1981; 2:143-95.
6. Lewis DW. Ontario adult dental visits: priorities, attitudes and insurance. Toronto: Dental Health Care and Epidemiology Research Unit, Univ. of Toronto, 1980 (Report No. 38).
7. Gray H, Gunther D. *A comprehensive review of dental caries experience shown by grade 7 students in the provincial health units of British Columbia, 1987*. Victoria, Victoria: Division of Dental Health Services, B.C. Ministry of Health, 1987.
8. Banting D, Hunt A, Baskerville J. Atlantic Canada children's oral health survey: summary report. London, Ontario: Faculty of Dentistry, Univ. of Western Ontario, 1985.
9. Locker D, Leake J, Otchere D. *Study of the oral health and treatment needs of Ontario's current and future elderly*. Toronto: Department of Community Dentistry, Univ. of Toronto, 1990.
10. Burgess RC. Diet and dental health. In: Health and Welfare Canada. *Preventive dental services*. 2nd ed. Ottawa: Minister of Supply and Services, 1988:50-85 (Catalogue No. H39-4/1988E).
11. Health and Welfare Canada. Preventive dental services: practices, guidelines and recommendations. Ottawa: Minister of Supply and Services, 1980 (Catalogue No. H39-4/1980E).
12. Health and Welfare Canada. *Preventive dental services*. 2nd ed. Ottawa: Minister of Supply and Services, 1988 (Catalogue No. H39-4/1988E).
13. Reisine ST. Social, psychological and economic impacts of dental conditions and treatments. In: Cohen LB, Bryant P, editors. *Social science and dentistry*. Vol 2. The Hague: Quintessence Publishing Co., 1984.
14. Chambers DW. Patient susceptibility to the effectiveness of preventive oral health education. *J Am Dental Assoc* 1977; 95:1159-63.

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Book Reviews

Dentistry, Dental Practice and the Community, 4th ed.

Burt BA Eklund SA.

Philadelphia, PA: Saunders, 1992: 339 pp.

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Reviewed by: Joanne Clovis, Dip DH, BEd, MSc
Associate Professor and Director, School of
Dental Hygiene, Dalhousie University
Halifax, Nova Scotia

At last, a textbook which begins with a chapter titled, "The Professions of Dentistry and Dental Hygiene"! The authors frequently and deliberately use the term dental professionals to "...include both dental hygienists and dentists as colleagues working together toward a common goal." Even the issue of the gender specific pronoun is dealt with in a unique fashion by making it feminine in odd numbered chapters, and masculine in the even numbered. Reading on, however, the use of titles and headings and terms such as dental professionals dissolves into carefully neutral text with regard to the profession of dental hygiene.

The fourth edition of this comprehensive text is an essential reference for both dental and dental hygiene students and practitioners. The authors stated purpose is "to present dentistry and dental practice against the backdrop of social events: economic, technological, and demographic trends, as well as the distribution of the oral diseases that dental professionals treat and prevent." The authors note that profound changes have occurred since 1983, the year of the previous edition, and they extend the scope of this edition to several new chapters, including a chapter on the provision of dental care in Canada, in addition to the update of ongoing topics and issues.

Throughout, the text is thoroughly researched and referenced extensively. The book serves as an overview of many topics related to oral health with in-depth coverage of the social influences on oral health. The authors "see health as a major factor in a higher quality of life" and "oral health significantly improves the quality of life". Accordingly, the first three chapters look at the social roles

of the dental professionals, the public they (we!) serve, and our ethical responsibilities as dental professionals. Inexplicably, the authors, after referring to the "professions of dentistry and dental hygiene" go on to state that "Dental hygiene is usually considered a profession within dentistry...", and it is this sort of statement that leaves the reader, and the public, confused.

Notwithstanding this mild offense to our professional sensitivity as dental hygienists, the text continues on with excellent writing and references. Chapter four suggests that all dental professionals have public health responsibilities and that "the partnership between public and private resources is the only way that everyone's dental needs can be taken care of". The comparison between personal and community health care is, as in previous editions, a useful description of the similarities.

The importance of "Reading the Dental Literature" is emphasized by relocating the chapter from its previous designation as Chapter Ten to Chapter Five in the current edition. The authors state that "literature is the primary source of new knowledge" and dental professionals must therefore be able to locate and read dental literature critically. The essentials of research design and the criteria for judging journal reports are included. Methods of statistical analysis and presentation of data are intentionally omitted although the issue of statistical significance is elucidated.

Chapter six is a comprehensive critique of indices for caries, periodontal disease, and dental fluorosis along with methods of measuring other oral conditions including malocclusion, oral cancer, and clefts. The issues of examiner reliability and assessment of disease risk are given special emphasis.

Epidemiologic summaries of tooth loss, caries, periodontal diseases, oral cancer, clefts, malocclusion and TMJ disorders are provided in chapters seven through ten. Determinants and risk factors for caries and periodontal diseases are reviewed in detail. The decline of dental caries is examined and the suggestion is made that the causes for the

decline are not clear. Perception of periodontal disease have changed radically in the past decade and the current perceptions are concisely summarized.

Chapters 11 through 17 focus on the prevention of oral diseases. Chapter 11 is an account of the discovery of the dental benefits of fluoride through one of the greatest epidemiological studies in all health research. The human physiology of fluoride, the mechanisms of fluoride action in the prevention of caries, fluoride toxicity and fluorosis are elaborated. The issue of dental fluorosis as a public health problem is carefully examined with reassurance about the current prevalence and severity in United States, but cautionary notes regarding future risk. Chapter 12 is devoted to the history and policies of fluoridation. Chapter 13 examines other fluorides used in caries prevention with attention to the additive effects of multiple sources of fluoride and the useful reminder that "...clinical judgment in these decisions should always be guided by experimental data."

Pit-and-fissure sealants, the subject of Chapter 14, are once again strongly advocated. Despite the development of standards by the American Dental Association for the use of sealants in dental insurance programs, the acceptance of sealants by dentists and reimbursement by insurance companies are unreasonably low.

In Chapter 15, the evidence linking diet and plaque control with caries is reviewed. Recommendations for individual and community dietary and plaque control interventions are based on the weight of the research evidence which does not clearly link either diet control or oral hygiene with caries prevention. The social and periodontal benefits of oral hygiene are reinforced along with the caries prevention benefits of fluoride toothpaste during brushing.

Chapter 16 assesses mechanical plaque removal by the individual and the dental professional, and chemotherapeutic methods of plaque control as three approaches to preventing the accumulation of plaque with its consequences in terms of gingivitis, calculus

formation, and potential for development of periodontal diseases.

Chapter 17 examines the issue of reducing the consumption of smokeless tobacco, especially among young people. Infection control and mercury safety are the subjects of Chapter 18. These issues which are potential hazards to individual safety and the environment are clearly public health concerns.

Chapter 19 is a brief introduction to the promotion of oral health with reference to global and U.S. goals for oral health by the year 2000. Although Canada has been a recognized leader in health promotion activity, Canadians have not received the benefits of either a major review of oral health status in Canada or the establishment of oral health objectives. The U.S. objectives provide us with a clear example of what might be done in Canada if oral health ever reached the national health agenda. Reference is made to the knowledge gaps concerning preventive procedures among researchers, practitioners, and patients, as well as the lack of consensus between researchers and practitioners regarding the effective promotion of caries prevention. The authors suggest that health promotion activities aimed at changing attitudes and practices of both patients and practitioner can alleviate this confusion, and that dental and dental hygiene curricula must include health promotion knowledge, skills, and attitudes.

The structure of dental practice, financing dental care, and dental personnel are the subjects of Chapters 20 to 22. While there is some reference to primary health care and dental care delivery systems other than those in North America, Chapter 20 is essentially a review of dental care delivery in the United States with reference to the private practice philosophy. The financing of dental care in Chapter 21 is comprehensive but "pre Clinton" by date and, consequently, does not alert the reader to the current potential for the inclusion of oral care in a national health care program in the United States. The concluding statements is, however, worth repeating here: "Ultimately, the economic cost of introducing NHI (National Health Insurance) must be balanced against the social cost of not introducing it."

Chapter 22 provides some helpful comments and cautions about predicting dental personnel requirements. "What kind" and "how many" are value-laden decisions. The references to dental hygienists, however, continue to be made under the heading of "dental auxiliaries". The current issues of

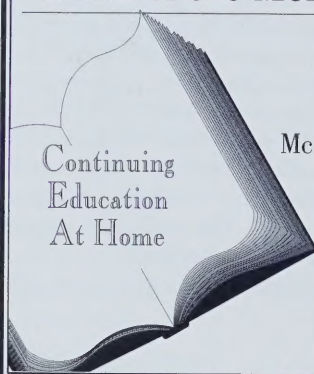
dental hygiene autonomy and professionalism are addressed in a direct manner with no reference to the enormous potential for public benefit through increased provision of dental hygiene services in the prevention or oral disease.

The final chapter, "The Provision of Dental Care in Canada" by Dr. D.W. Lewis of the University of Toronto, is a much needed accounting of the history and current status of oral health, dental care delivery, dental personnel and public health programs in Canada. Reference is made to the "pluralistic"

approach to the provision of dental care in Canada with the fee-for-service private practice model being modified by a wide variety of government and private dental care plans.

This text continues to be an essential reference in dental public health for the U.S. and, with the addition of the chapter on dental health in Canada, it is the best available reference on the dental health of the public in Canada and the U.S.

CDHA's Book of the Month Suggestion



November:
Reflective Teaching
James G. Henderson
McMillan Publishing 1992
ISBN #0-02-353511-3

December:
Fifth Discipline
Peter Senge
Doubleday Press 1990
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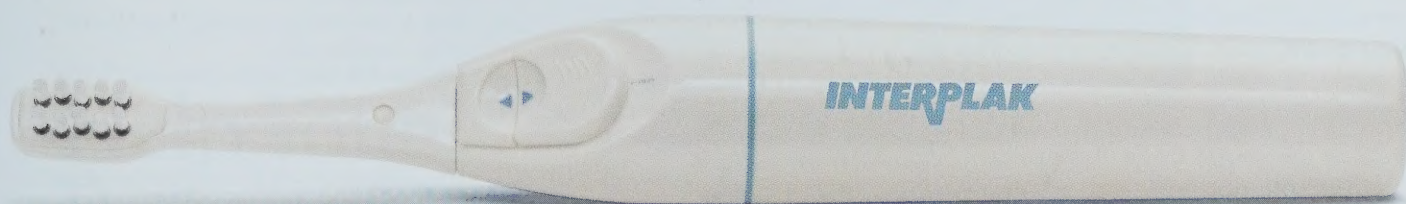
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Help Your Patients Help Themselves To A Healthier Oral Environment with Oxygene®, Stabilized Chlorine Dioxide (ClO₂)

- 🌿 Perfect complement to a successful soft tissue program.
- 🌿 Patients love the products and the results.
- 🌿 Oxyfresh™ products are 100% satisfaction guaranteed.
- 🌿 ClO₂ will not stain like chlorhexadine.
- 🌿 Alcohol free.
- 🌿 Oral malodor reduced by removing volatile sulfur compounds (VSCs).
- 🌿 ClO₂ is a safe, approved disinfectant for VSCs.
- 🌿 Increases patient home care compliance.
- 🌿 Excellent oral rinse before dental procedures.

**Oxyfresh
+
Soft Tissue
Program**



**Great
Compliance
+
Grateful
Patients**

“

“Oxyfresh Mouthrinse, Toothpaste and Gel, together with the OxyCare 3000 is the best soft tissue home care program I’ve

seen.” Max L. Schaeffer, DDS, MS
Periodontist & Oral Implantologist-Tucson, AZ

“The Hydromagnetic OxyCare 3000 Oral Irrigator and Mouthrinse with Oxygene® has been of tremendous value in controlling malodor in our orthodontic and post-surgical orthognathic patients.” Robert C. Penny, DDS, MS Orthodontist, Weatherford, TX

“Our patients love the results without staining, alcohol toxicity, and bad taste.” Carol Walters, RDH Yuba City, CA

“Oxyfresh Oral Health Care products containing Oxygene are the best adjuncts available to use with a progressive in-office STM. Coupled, they create an incredible and unlimited value-based practice with superior clinical results.” Charles R. Griffin, Jr., DDS, FAGD-Tucson, AZ

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your patients. Call today for details.**

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*OxyCare™ 3000 and Breathmints are temporarily unavailable in Canada.



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Dental hygienist — full time
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THE LUNG ASSOCIATION

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Cranbrook, BC

Wanted — experienced hygienist to work with easy-going and friendly staff in a lovely new office, and in the most beautiful corner of British Columbia, offering the utmost in recreational activities and scenery, yet still not too far away from those city excursions.

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Dr. John W. Nesbitt
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V1C 3P8

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Please submit resume to:

Dr. P.M. Crosson & Dr. L. A. Barnes
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Fifty (50) words or less, per ad, minimum \$25.00 plus 7% GST (total: \$26.75). Each additional word 50¢ plus 7% GST (total: 54¢). Payment must accompany order or ad will not be placed. Closing date for receipt of copy is the 1st day, two months previous to publication date — November 1 for January/February issue, January 1 for March/April issue, March 1 for May/June issue, May 1 for July/August issue, July 1 for September/October issue, and September 1 for November/December issue. Display classified rates based on 1/2 page (\$400.00 plus 7% GST, total: \$428.00) and 1/4 page (\$200.00 plus 7% GST, total: \$214.00). Non cancellable after closing date. No agency commissions on classified advertising. Ads will not be taken by telephone.

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Ottawa, Ontario K1Z 6A5

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2018



FIGHTS CAVITIES

Trident

WITH DENTEC
AVEC
COMBAT LA CARIE

Reduce cavities by up to 62%.*

A two year study now proves that Trident[†] gum, when chewed in conjunction with a program of regular oral hygiene, actually reduces cavities by up to 62%.*

Trident has been granted approval for this claim because a study has shown that Xylitol, used in Trident, significantly reduced the DMF increment among a large research population.

Xylitol, or Dentec[†] - a name we developed to aid consumer awareness - disrupts the plaque matrix which contains the caries-causing streptococcus mutans.

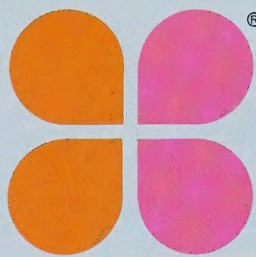
Consequently, Trident gum which contains 15% Dentec/ Xylitol, provides an anticariogenic benefit that other gums do not.



In addition, Trident gum is now recognized by the Canadian Dental Association, which is significant for the fact that it is the first gum to be so acknowledged.

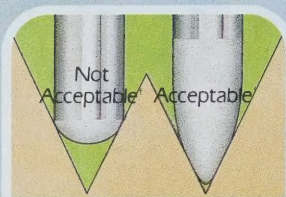
What this means is, now, dental professionals can recommend, with confidence, Trident gum with Dentec as part of a complete program of oral hygiene. For more information call 1 800 263 9060.

Butler



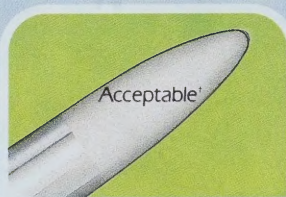
GIVE YOUR PATIENTS THE BUTLER ADVANTAGE

Only Butler toothbrushes provide these 5 features



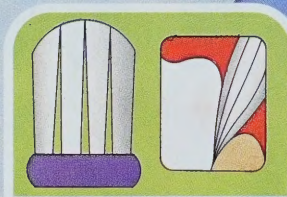
Rounded and Tapered Bristles

Rounded to be gentle, not traumatize gums. Tapered to reach deep into the sulcus and interproximally. Bristle tips are sized down from .004 to .002.



Satinized Bristles

Butler's texturized bristles pick up plaque and carry it away, unlike some smooth, polished bristles that only slide through plaque.



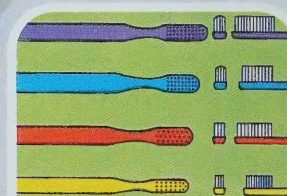
Dome-Shaped Trim

Exclusive shape prevents bristles from bunching up, allowing a flexible tip to penetrate sulcular areas. The design positions bristles to reach into the sulcus regardless of angle.



Wide Straight Handle

The wide, lever grip straight handle provides better grip for more precise control of brush head making it easy to brush the buccal, lingual, posteriors as well as anteriors. And it won't twist in your hand.



The Right Size & Style

Large or small arches, adults, children, or youths. Butler has the most complete range of brushes available, so you can provide exactly the right brush for every patients' needs.

DENTIST DESIGNED CLINICALLY PROVEN

These exclusive features of the Butler toothbrush provide the basis for its superb clinical performance. Butler toothbrushes are proven in independent studies* to reduce gingivitis and are the overwhelming choice of Periodontists.

Next time you recommend, dispense or use a toothbrush, give your patients and yourself The Butler Advantage.

*Data on file.

†According to Butler Specifications



Butler



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